EXHIBIT A

To: lossnoticemwia <lossnoticemwia@unitedfiregroup.com>, United Fire Group WebMaster <Webmaster@unitedfiregroup.com>
From: United Fire Group WebMaster <Webmaster@unitedfiregroup.com>
Date: Tue, 24 May 2011 16:39:14 -0500
Subject: New Auto Loss Report for SD

The attached claim was submitted via the Internet for, PLUCKER DEBBIE, to United Fire Group. The confirmation number for this notice is 26106.

(If there is no attachment on this email, please contact Web Help at 1-800-895-6253.)

IRFILENO:90625038
Userdata1:230299
Server:www.unitedfiregroup.com

Claim #: 4001032727 KKH Printed: 05-25-2011

UNITED FIRE & CASUALTY COMPANY
NOTICE OF NEW CLAIM ASSIGNMENT

Email SWADE@UNITEDFIREGROUP.COM

SHERRI WADE
PO BOX 73909

CEDAR RAPIDS IA 52407-3909
Bus Phone 319-399-5758

Claim No: 4001032727
Loss Date: 05-24-2011
Pol Period: 03-30-2011 to 09-30-2011
Policy No: 90625038 COB: 0110
Reinsurance-ACL: NO
Superv: SNIFFIN ROBERTA AFA: N
Subro Supv:
Subro Rep: RST:

----------AGENT----------

BRENNER & JUSTICE INS INC 230299
JUDY BRENNER

Phone 605-362-8200
Fax 605-362-9366

----------INSURED----------

DEBBIE PLUCKER

	Ext
Oth 605-728-5595	0
000-000-0000	0
000-000-0000	0

45730 SD HIGHWAY 44
PARKER SD 570535624
Email DVPLUCKER@AOL.COM
Email2
SSN/FEIN

Contact:

	Ext
45730 SD HIGHWAY 44 Oth 605-728-5595	0
000-000-0000	0
PARKER SD 57053 000-000-0000	0

Email: DVPLUCKER@AOL.COM

When:
Where:

Claim Type: Auto PIP/MEDICAL/INCOME CLAIM ONLY Est 0
Location of Occurrence Time 11:00AM Cat No
I-29 N AT (MRM 071-63 + .108
HARRISBURG SD 57032

Authorities
SDHP

Violations
UNKNOWN

Report #:

Loss Description Coverage File: N
A SEMI TRACTOR/TRAILER RIG LOST BOTH REAR TANDEMS WHICH HIT THE SEMI THAT WASIN FRONT OF THE INSURED AND THEN BOUNCED OFF THAT TRUCK AND HIT OUR INSURED.

UF000002

Claim #: 4001032727 KKH Printed: 05-25-2011

Insured Driver A/M Ind. A
DEBBIE PLUCKER
Oth 605-728-5595 Ext 0
000-000-0000 0
45730 SD HIGHWAY 44 SSN
PARKER SD 57053 DOB: Sex F
Email1 DVPLUCKER@AOL.COM
Email2
Type DRIVING License St SD Lic# 00588887
Date Hire Relation POLICYHOLDER #1
Fault UNDETERMINED Freeform Rel. INSURED
Used w/Permis. Yes Purpose PERSONAL

Clt No. 001
DEBBIE PLUCKER
45730 SD HIGHWAY 44
PARKER SD 570535624
Oth 605-728-5595 Ext 0
0

RISK 014 2011 CHEVROLET SILVERADO C SSN 000000000
1GCRCSE07BZ331885 Sex Age 51

Damage
Where Damage can be Viewed
What Doing
Injury
Where Taken
Remarks

Cover	LC	Reserve	Type	Adjuster-1	Adjuster-2	TLS	SI
COLL	AU	1,250.00	F	WADE SHERRI			
MP	AU	1,250.00	F	WADE SHERRI			

** ** R E M A R K S * * R E M A R K S * * R E M A R K S * * R E M A R K S ** **

ASSIGNMENT TRANSMITTAL
Loss notice statews that insured is going to try to
collect for her damages from the other carrier.
If you don't need the collision line, I can close it

INSURED HAS FILED CLAIM WITH DAKOTALAND, INC. FOR HER VEHICLE. (THE LOCAT
ION OF THE ACCIDENT IS CORRECT MILE MARKER # BUT THE CITY PROBABLY IS NOT.
YOUR SYSTEM REQUIRED ME TO PUT ONE IN BUT THERE ISN'T ONE ON THE HP REPO
RT AND THEY WEREN'T AT A CITY).

Report Date Reported By Insured Phone: 000-000-0000 Ext 0
05-24-2011 Reported Name

Claim #: 4001032727 KKH Printed: 05-25-2011

---------- VEHICLE COVERAGE INFORMATION ----------

[redacted]

CSL			
BI per Per	50000		
BI per Acc	100000	PIP	
PD	50000	APIP	
[redacted]		Opt 1	
[redacted]		Opt 2	
UM BI per Acc	100000	Opt 3	
UM PD		PIP on MC?	
UM PD Ded		PIP Ded	
UIM per Per	50000	ADB	
UIM per Acc	100000	ADB Work Loss?	
Coll Ded	500	Towing	SMP? N
Comp	Y	Trans exp per day	UMPD?
Comp Ded	500	Trans exp per occ	LPIP?N
Stated Amt			
Loss Payee			

Geo Code: Lat: 0000000000+ Long: 0000000000+ Confid: Date:

Form #	Ed Dt	Form Description
IL7009	0491	PUNITIVE OR EXEMPLARY DAMAGES EXCL
[redacted]		
PP0165	1010	SD - AMENDMENT OF POLICY PROVISIONS
PP0311	0698	UNDERINSURED MOTORISTS COVERAGE
PP1301	1299	DAMAGE TO YOUR AUTO EXCLUSION
PP7023	0209	ROADASSIST 24/7
ST1393	0701	IMPORTANT PRIVACY NOTICE
ST1492	1003	NOTICE FAIR CREDIT REPORTING ACT
ST1623	0707	NOTICE - IDENTITY RECOVERY
ST1644	0109	POLICY WEBSITE STUFFER

==========

==========

1/30/2012 3:26:19 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Reviewed on diary

I presented to the insured, Debbie Plucker an alternative to signing the med auth as outlined in my August 3rd letter. If she wishes to have us use her med pay she can just pick up her medical bills at Lanpher Chiro and forward to us directly.

Thus, far she has eschewed this option.

Roberta

==========

1/4/2012 10:28:54 AM - SWADE-Sherri Wade

CLMS - 4001032727

I spoke with the adverse carrier, he said he thought he had an agreement with the insd but then she said she was going to contact an atty and he hasn't heard from her since.

==========

12/12/2011 2:19:31 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Reviewed on diary

Looks like Debbie will be settling w/ adverse and getting her bills paid there-- Okay by us--

Roberta

==========

11/16/2011 2:22:45 PM - SWADE-Sherri Wade

CLMS - 4001032727

I spoke with Derron with the other carrier, he has not concluded this with the insd and still hopes to do so shortly & pay all of the meds directly. He said he will call me once it's done.

==========

11/15/2011 9:07:07 AM - SWADE-Sherri Wade

CLMS - 4001032727

Noted & agreed. I have this on diary until January to make sure the other carrier paid the same.

==========

11/14/2011 2:20:28 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Reviewed file on diary

Sherri--

Really, we do not have ORM here because the insured refused to sign a med auth. However, unless adverse pays her bills; Medicare will present subro to us. So I do not see that we can close until we have received same.

Food for thought.

Thanks

Roberta

==========

9/28/2011 3:19:28 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Reviewed on diary

RES

==========

9/27/2011 3:13:09 PM - SWADE-Sherri Wade

CLMS - 4001032727

Clmt carrier called and it sounds like they will be settling with the insd directly in the next few weeks. I will leave the file open until any settlement is confirmed.

==========

9/27/2011 2:26:40 PM - SWADE-Sherri Wade

CLMS - 4001032727

Returned a call to adv carrier and advised we have not made any payments on behalf of the insd.

==========

9/2/2011 10:53:57 AM - SWADE-Sherri Wade

CLMS - 4001032727

Noted

==========

8/31/2011 12:32:47 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Sherri--

File on diary

Appears that Medicare has accepted our notice-- Debbie either sends her bills into us w/ the records or we wait for subro from Medicare and pay accordingly.

I've discussed w/ agent and said we need cooperation from Debbie.

The agent advised that Debbie prefers that you do not call her again so if you have to call for anything-- send file to me and I will help.

This a small file so not going to make a big deal out of Debbie's refusal to help us help her-- We have a QR in the works and she said she was canceling us anyway.

Thanks

Roberta

==========

8/10/2011 3:46:45 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Received a call from Mary at Dr. Lancer's office-- Debbie told her about the Med Auth problem. Mary said to Debbie that she cannot just mail us the medical records because of HPPA but that she will talk to the Dr. about just giving Debbie a copy.

I advised Mary that the Med Auth Debbie signed for us will not fly as all crossed out etc. Mary said she tried to explain the procedure to Debbie, but she will not just sign a Med Auth.

Again, Mary will see if Dr. Lancer will just let Debbie have her own records to give us.

Roberta

==========

8/4/2011 10:31:07 AM - SWADE-Sherri Wade

CLMS - 4001032727

Returned a call to Derrin at Liberty Mutual at 877-884-1799 ext 3845. His claim AB3961-070925. Advised I have not paid out MP yet & expect to do so and will update him when I have made any payments.

==========

8/3/2011 10:06:22 AM - SWADE-Sherri Wade

CLMS - 4001032727

Noted

==========

8/3/2011 9:56:45 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

While I was typing that letter Debbie called-- I advised her of exactly what I put in the letter. She will obtain records next week as well as a billing log and mail into us.

Roberta

==========

8/3/2011 9:56:04 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Sherri--

I have mailed a letter to Debbie Plucker and e-mailed a copy to her agent, Kathy Justice. No need to leave her messages anymore because she will not answer them as she is angry about us not just paying her bills.

I've offered her an alternative to the Medical Authorization which is to obtain her medical reports herself and send into us. Please advise if you receive because we want to make sure they are complete. Also, if Medicare is paying I've let her know, we must set aside same.

RES

==========

7/29/2011 10:35:09 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Called Debbie Plucker as I advised the agent I would do same to discuss the Med Auth and if she does not want to sign, some alternatives.

Left a call back message

Roberta

==========

7/26/2011 1:44:30 PM - SWADE-Sherri Wade

CLMS - 4001032727

Roberta:

Yes I have already spoken with Liberty Mutual and they have adequate limits. They have also accepted liability.

I sent a QR.

Thanks!

Sherri

==========

7/25/2011 3:46:31 PM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Sherri--

Because adverse vehicle is a truck, I would assume that they have liability limits equal too or greater than ours so UIM would be ruled out-- on diary just make a call to Liberty Mutual to make sure if you have not done same yet.

Should we QR this insured? What do you think?

Thanks

Roberta

==========

7/22/2011 11:31:23 AM - SWADE-Sherri Wade

CLMS - 4001032727

I left the insd a message to call bc she returned a med auth & blacked half of it out. I'm not sure what is going on with the insd. She is being illusive now and uncooperative.

I spoke with the agt Kathy & she said she'd make a call to insd.

==========

7/13/2011 10:32:12 AM - SWADE-Sherri Wade

CLMS - 4001032727

I left the insd another message today and also sent her a letter outlining her obligations with the policy. We are almost 2 months since the loss and no meds auths but receiving bills.

==========

7/5/2011 3:46:37 PM - SWADE-Sherri Wade

CLMS - 4001032727

I left the insd a message to get add'l info so we can complete the forms required by medicare that were received today.

==========

6/30/2011 2:14:53 PM - SWADE-Sherri Wade

CLMS - 4001032727

I left the insd a message to f/u on med auths

==========

6/14/2011 9:56:49 AM - SWADE-Sherri Wade

CLMS - 4001032727

I spoke with the insd. She is filling out the med auths today. She said she is having some post traumatic stress associated with seeing the wheel fly across the highway. She said she is having some trouble with her fear of driving now. She hopes it will go away and has not tx for this. She said her neck & shoulder still bother her, especially when she is sleeping. She is tx 1/per week b/c the DC is 90 miles round trip. We discussed the concerns that arise when the stop wasn't forceful enough to tighten her seat belt and weeks later she is still sore. She said maybe she forgot & her seat belt did tighten.

==========

6/6/2011 11:04:34 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Completing diary early as received CAP report

Claimant vehicle has accepted fault, we have subrogatable MP -- Insured disabled and collects Medicare. Need to watch treatment closely.

Roberta

==========

6/6/2011 11:02:20 AM - RSNIFFIN-Roberta Sniffin

CLMS - 4001032727

Sherri--

File looks good as does the claimant screen. Watch saying yes to ORM until we get the Medical Authorization. While I like that you are on top of it, until they sign the Med Auth it is not official. This one is ready to go already though so I would not change a thing.

Roberta

==========

6/6/2011 10:57:33 AM - SWADE-Sherri Wade

CLMS - 4001032727

I called the insd. She said she's been having some trouble getting her mail and does not remember seeing our med auths. I printed the ones I sent her previously and mailed them again.

==========

5/26/2011 1:28:39 PM - SWADE-Sherri Wade

CLMS - 4001032727

Derron from Liberty Mutual said they will not let their insd give us a statement but they have accepted liability. Apparently his insd does all the work on their own trucks. His address is PO Box 168328, Irving, TX 75016.

==========

5/26/2011 11:14:53 AM - KHARRIS-Kiley Harris

CLMS - 4001032727

so noted have sent for police report and asked for narrative

==========

5/26/2011 11:12:45 AM - SWADE-Sherri Wade

CLMS - 4001032727

The other carrier is Liberty Mutual, adj: Derron Lax, Claim: AB961-070925, phone: 877-884-1977.

==========

5/26/2011 11:10:46 AM - SWADE-Sherri Wade

CLMS - 4001032727

I left message for the other driver and the other carrier to call.

==========

5/26/2011 11:06:22 AM - SWADE-Sherri Wade

CLMS - 4001032727

Kiley:

Will you please order a copy of the PR and maybe we can get a copy with some kind of narrative?

Thanks a bunch!

Sherri

UNITED FIRE GROUP
MEDICARE QUARTERLY RESPONSE RECORD
RESPONSE DATE 02/08/2012

CLAIM 4001032727
CLAIMANT 001

	SUBMITTED	RETURNED
ACTION	DELETE	
HICN		
SSN		
LAST NAME	PLUCKER	PLUCKER
FIRST NAME	DEBBIE	DEBBIE
MIDDLE INIT		L
GENDER	F	F
DOB		
POLICY #	011090625038	
MSP EFFECT DT		05/24/2011
MSP TERM DT		
TYPE IND		D - NO FAULT
DISPOSITION CD		01 RECORD ACCEPTED WITH ORM
APPLIED ERROR CODE		

APPLIED COMPLIANCE FLAG(S)

Reviewed slg 02/09/2012 09:39

UNITED FIRE GROUP
Report to: Supervisor Roberta Sniffin

Transcriber:
Date: 1/4/12

Claim No. **4001032727**
Insured: **Debbie Plunker**
Adjuster: **S Wade**
Dictated Date:
Adjuster Initials: sig

Supervisor Initials and Date through Image Right:

FILE STATUS UPDATE

ENCLOSURES

res 01/04/2012

1) Medicare update

FILE STATUS/UPDATE

The other carrier had hoped to have this resolved with the insd by now and I confirmed today that a resolution has not been met. The insd is aware we are here and does not want to speak to us. I suggest we diary this file out another 6 months so if the insd decides to use MP, we are ready and perhaps by then she will have resolved with the other company.

RESERVES

Verified in ACS today? ☒Yes ☐No Reserves Adequate? ☒Yes ☐No

Reserve amounts, analysis and recommendations:

Insd Debbie Plunker:
MP: $1,250 reserved, $5k limit

NEXT REPORT DUE/FURTHER ACTION NEEDED

A 6 month diary will put us to 7/6/12. Thank you.

UNITED FIRE GROUP
MEDICARE QUARTERLY RESPONSE RECORD
RESPONSE DATE 11/09/2011

CLAIM 4001032727
CLAIMANT 001

	SUBMITTED	RETURNED
ACTION	DELETE	
HICN		
SSN		
LAST NAME	PLUCKER	PLUCKER
FIRST NAME	DEBBIE	DEBBIE
MIDDLE INIT		L
GENDER	F	F
DOB		
POLICY #	011090625038	
MSP EFFECT DT		05/24/2011
MSP TERM DT		
TYPE IND		D - NO FAULT
DISPOSITION CD		01 RECORD ACCEPTED WITH ORM
APPLIED COMPLIANCE FLAG(S)		

Reviewed slg 11/14/2011 16:20

UNITED FIRE GROUP
Report to: Supervisor Roberta Sniffin

Transcriber:
Date: 10/5/11

Claim No. **4001032727**
Insured: **Debbie Plunker**
Adjuster: **S Wade**
Dictated Date:
Adjuster Initials: slg

Supervisor Initials and Date through Image Right:

FILE STATUS UPDATE

ENCLOSURES

1) Your correspondence with the insd & agt *res 10/05/2011*
2) Medicare response

FILE STATUS/UPDATE

The Insd has still not responded to us. The Clmt carrier called on 9/27/11 and it sounds like they will be settling with the insd directly in the next few weeks. I will leave the file open until any settlement is confirmed.

RESERVES

Verified in ACS today? ☒Yes ☐No Reserves Adequate? ☒Yes ☐No

Reserve amounts, analysis and recommendations:

Clmt 1 Debbie Plucker:

MP: $1,250 reserved/$5k limit

NEXT REPORT DUE/FURTHER ACTION NEEDED

90 days to 1/6/12. Thank you.

UNITED FIRE GROUP
MEDICARE QUARTERLY RESPONSE RECORD
RESPONSE DATE 08/10/2011

CLAIM 4001032727
CLAIMANT 001

	SUBMITTED	RETURNED
ACTION	ADD	
HICN		
SSN		
LAST NAME	PLUCKER	PLUCKER
FIRST NAME	DEBBIE	DEBBIE
MIDDLE INIT		L
GENDER	F	F
DOB		
POLICY #	011090625038	
MSP EFFECT DT		05/24/2011
MSP TERM DT		
TYPE IND		D - NO FAULT
DISPOSITION CD		01 RECORD ACCEPTED WITH ORM
APPLIED COMPLIANCE FLAG(S)		

Reviewed slg 08/12/2011 09:41

To: JUSTICE KATHRYN E;
From: RSNIFFIN
Cc:
Bcc:
Subject: Plucker
Date/Time Sent: 8/3/2011 9:58 AM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

Kathy--

Just as soon as I finished my letter and e-mailed to you-- Debbie called-- I advised her of the information in the letter and she will obtain her medical records and mail into us.

Thanks

Roberta

==========END OF MESSAGE==========

Attached Files:
IR110000.pdf

To: JUSTICE KATHRYN E;
From: RSNIFFIN
Cc:
Bcc:
Subject: Plucker claim
Date/Time Sent: 8/3/2011 9:50 AM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

Kathy--

I was unable to reach Debbie by telephone so I am sending her this letter advising that if she can provide the Medical records from her DC, Lanpher Chiro-- we can review for payment. I also wanted her to understand if Medicare paid anything, we have to pay them back.

If she contacts you with questions, please direct her to me and I can help.

Thanks!

Roberta E. Sniffin, CPCU
United Fire Group
Claim Supervisor

==========END OF MESSAGE==========

Attached Files:
IR110000.pdf

August 3, 2011

Debbie Plucker
45730 SD Hwy 44
Parker, SD 57053-5624

Claim: 4001032727

Dear Ms. Plucker:

Thank you for forwarding your signed medical authorization. Unfortunately, it will not be accepted by any medical facility with all of the changes made to the document.

If you do not wish to complete a medical authorization, then I can present another solution which is to obtain your medical records from Lanpher Chiropractic Office and forward to us. We will then review same for payment. Please do note that with Medicare's involvement if they have paid any monies, we must set aside that amount of your Medical Payments coverage to pay them back.

If you have any questions, feel free to contact me at 1-800-343-9131, ext. 5430.

Sincerely,

Roberta E. Sniffin, CPCU
United Fire Group
Claim Supervisor

UNITED FIRE GROUP
Report to: Supervisor Roberta Sniffin

Transcriber:
Date: 8/3/11

Claim No. **4001032727**
Insured: **Debbie Plunker**
Adjuster: **S Wade**
Dictated Date:
Adjuster Initials: sig

Supervisor Initials and Date through Image Right:

FILE STATUS UPDATE

ENCLOSURES

res 08/03/2011

1) Medicare Forms
2) Medical Auth from Insd
3) Letter to insd
4) QR

FILE STATUS/UPDATE

As you know, we've been attempting to assist the insd with her MP claim. We are having a difficult time helping her because she is not returning our calls. Insd returned the medical authorization but edited it to the point that we will not be able to use it. She also has not returned the Medicare forms and she is a Medicare recipient.

I tried calling her again today and got her voice mail. Instead of leaving a message, I have sent her a letter. Insd was initially friendly and cooperative and I do not understand her change in behavior. I will continue to try to reach her but at this point the agent has become involved, you & I have left messages and now I have written to her. In my letter of 7/13/11 I outlined her duties to cooperate.

We have received $876 in DC bills thus far that are unpaid.

RESERVES

Verified in ACS today? ☒Yes ☐No Reserves Adequate? ☒Yes ☐No

Reserve amounts, analysis and recommendations:

Debbie Plucker:

MP: $1,250 reserved/$5k limit

NEXT REPORT DUE/FURTHER ACTION NEEDED

60 days to 10/6/11. Thank you.

Did not mail since insd called in - slg 8/3/11

August 3, 2011

Debbie Plunker
45730 SD Highway 44
Parker, SD 57053

RE: Claim: 4001032727
Loss Date: 5/24/11

Dear Ms. Plunker,

I have been trying to reach you and have not been able to connect with you. I would like to assist you with your claim and need to speak with you. Will you please call me when you receive this letter? I can be reached Monday through Friday from 8:00am until 4:30pm at 800-343-9131 ext 5758.

Thank you!
Sincerely,

Sherri Wade, Claims Representative

To: Diefendorf, Tom;Haines, Michele;
From: KHARRIS
Cc:
Bcc:
Subject: QR FOR YOUR REVIEW
Date/Time Sent: 7/26/2011 2:21 PM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

==========END OF MESSAGE==========

Attached Files:
IR110000.tif

United Fire and Casualty Company

RISK ANALYSIS

CLAIM NO.: 4001032727
INSURED: Debbie Plucker
DOL: 5/24/11

COMMERCIAL LINES: ☐ OR PERSONAL LINES: ☒
AGENCY: Brenner & Justice
POLICY NO.: 90625038

Check applicable blocks and explain in remarks section.

GENERAL

- ☐ Physical impairment
- ☒ Insured uncooperative
- ☐ Poor area or adjoining hazards at location
- ☐ Loss frequency
- ☐ Unusual hazard (Explain)
- ☐ Premises or operations inconsistent w/policy description
- ☐ Drinking, drugs or gross negligence involved
- ☐ Change of address, occupation or marital status
- ☐ Photos in claim file

VEHICLE

- ☐ Vehicle in poor condition or with special equipment
- ☐ Vehicle not listed on policy
- ☐ Vehicle on policy not owned by insured
- ☐ Change of business classification or territory
- ☐ Extra hazards (Explain)
- ☐ Liability claim reserve/payment $
- ☐ Business use or drives over 10 miles to work
- ☐ Unmarried operator under 30
- ☐ Driver over 70
- ☐ Traffic citation disposition
- ☐ OWI/drug related conviction
- ☐ No drivers license or license revoked
- ☐ Driver not listed on policy
- ☐ Previous accidents or losses (Explain)
- ☐ Improper PIP/UM rejection
- ☐ Improper vehicle classification or usage
- ☐ Miscellaneous reasons (Explain)
- ☐ Photos in claim file

Name of Driver
Date of Birth
Relationship of Driver to Insured

W/C

- ☐ Injured under 18 or over 70
- ☐ Unsafe operations - poor housekeeping
- ☐ Overall quality of employees low
- ☐ Operations out of home state or extra hazardous
- ☐ Photos in claim file

REMARKS

[redacted]

Payments to date $0
Will immediate cancellation prejudice claims handling? No

Date: 7/26/11 Adjuster: S Wade

PD/IM/GL

- ☐ Late notice of claim
- ☐ Previous losses - date and type
- ☐ Insured's attitude - lack of cooperation (Explain)
- ☐ Under insured/over insured property value is $
- ☐ Insurance to value: Actual Cash Value / Replacement Cost
- ☐ Secondary residence
- ☐ Mobile home construction
- ☐ Business conducted on residential premises (Explain)
- ☐ Condition and age of property (Explain)
- ☐ Defective or badly worn roof
- ☐ Composition overlay on wood shingles
- ☐ Wood or corn pellet burning stove
- ☐ Upkeep of premises - Inside and outside (Explain)
- ☐ Handrails needed (Explain)
- ☐ Walks, drives or parking area in unsafe condition (Explain)
- ☐ Dangerous animals - type and breed (Explain)
- ☐ Swimming pool, hot tub, Trampoline or horse(s) on premises (Explain)
- ☐ Unfenced swimming pool / hot tub
- ☐ Boat used commercially or in tournaments (Fishing Included)
- ☐ Vacant or unoccupied - Vacant
- ☐ Risk isolated or inaccessible (Explain)
- ☐ Structure Below Average for Area
- ☐ High crime area (Explain)
- ☐ Unusual occupancy or area (Explain)
- ☐ Undesirable tenants
- ☐ Hazardous or unguarded machinery (Explain)
- ☐ Exposure hazards (Explain)
- ☐ Unsafe labor conditions (Explain)
- ☐ Risk incorrectly classified (Change in operations?) (Explain)
- ☐ Miscellaneous reasons (Explain)
- ☐ Photos in claim file

EXPLANATIONS

FOR UNDERWRITING DEPT. USE ONLY

Date: Reviewed by:

SENT TO U/W AND MARKETING
7-26-11 KKH

E-mail to U/W Rep. & Marketing Rep. & Print to file

United Fire and Casualty Company
RISK ANALYSIS

CLAIM NO.: 4001032727
INSURED: Debbie Plucker
DOL: 5/24/11

COMMERCIAL LINES: ☐ OR PERSONAL LINES: ☒
AGENCY: Brenner & Justice
POLICY NO.: 90625038

Check applicable blocks and explain in remarks section.

GENERAL
- ☐ Physical impairment
- ☒ Insured uncooperative
- ☐ Poor area or adjoining hazards at location
- ☐ Loss frequency
- ☐ Unusual hazard (Explain)
- ☐ Premises or operations inconsistent w/policy description
- ☐ Drinking, drugs or gross negligence involved
- ☐ Change of address, occupation or marital status
- ☐ Photos in claim file

VEHICLE
- ☐ Vehicle in poor condition or with special equipment
- ☐ Vehicle not listed on policy
- ☐ Vehicle on policy not owned by insured
- ☐ Change of business classification or territory
- ☐ Extra hazards (Explain)
- ☐ Liability claim reserve/payment $
- ☐ Business use or drives over 10 miles to work
- ☐ Unmarried operator under 30
- ☐ Driver over 70
- ☐ Traffic citation disposition
- ☐ OWI/drug related conviction
- ☐ No drivers license or license revoked
- ☐ Driver not listed on policy
- ☐ Previous accidents or losses (Explain)
- ☐ Improper PIP/UM rejection
- ☐ Improper vehicle classification or usage
- ☐ Miscellaneous reasons (Explain)
- ☐ Photos in claim file

Name of Driver
Date of Birth
Relationship of Driver to Insured

W/C
- ☐ Injured under 18 or over 70
- ☐ Unsafe operations - poor housekeeping
- ☐ Overall quality of employees low
- ☐ Operations out of home state or extra hazardous
- ☐ Photos in claim file

REMARKS

[redacted]

Claim is ☒ Open ☐ Closed
Payments to date $0
Will immediate cancellation prejudice claims handling? No

Date: 7/26/11 Adjuster: S Wade

PD/IM/GL
- ☐ Late notice of claim
- ☐ Previous losses - date and type
- ☐ Insured's attitude - lack of cooperation (Explain)
- ☐ Under insured/over insured property value is $
- ☐ Insurance to value: Actual Cash Value / Replacement Cost
- ☐ Secondary residence
- ☐ Mobile home construction
- ☐ Business conducted on residential premises (Explain)
- ☐ Condition and age of property (Explain)
- ☐ Defective or badly worn roof
- ☐ Composition overlay on wood shingles
- ☐ Wood or corn pellet burning stove
- ☐ Upkeep of premises - Inside and outside (Explain)
- ☐ Handrails needed (Explain)
- ☐ Walks, drives or parking area in unsafe condition (Explain)
- ☐ Dangerous animals - type and breed (Explain)
- ☐ Swimming pool, hot tub, Trampoline or horse(s) on premises (Explain)
- ☐ Unfenced swimming pool / hot tub
- ☐ Boat used commercially or in tournaments (Fishing Included)
- ☐ Vacant or unoccupied - Vacant
- ☐ Risk isolated or inaccessible (Explain)
- ☐ Structure Below Average for Area
- ☐ High crime area (Explain)
- ☐ Unusual occupancy or area (Explain)
- ☐ Undesirable tenants
- ☐ Hazardous or unguarded machinery (Explain)
- ☐ Exposure hazards (Explain)
- ☐ Unsafe labor conditions (Explain)
- ☐ Risk incorrectly classified (Change in operations?) (Explain)
- ☐ Miscellaneous reasons (Explain)
- ☐ Photos in claim file

EXPLANATIONS

FOR UNDERWRITING DEPT. USE ONLY

Date: Reviewed by:

E-mail to U/W Rep. & Marketing Rep. & Print to file

CD1046 Risk Analysis (06/2010)

UF000029

To: JUSTICE KATHRYN E;
From: SWADE
Cc:
Bcc:
Subject: Debbie Plucker Claim
Date/Time Sent: 7/22/2011 11:32 AM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

==========END OF MESSAGE==========

Attached Files:
IR110000.pdf

UNITED FIRE GROUP
MEDICARE MONTHLY RESPONSE RECORD
RESPONSE DATE 06/09/2011

CLAIM 4001032727
CLAIMANT 001

	SUBMITTED	RETURNED
HICN		
LAST NAME	PLUCKE	PLUCKE
FIRST INITIAL	D	D
DOB		
GENDER	F	F
SSN		
RRE DCN1	20110531400103272700l	20110531400103272700l
RRE DCN2		
DISPOSITION CD		01 ID'D AS A MEDICARE BENEFICIARY
HICN UPDATED IN ACS		

Reviewed slg 06/09/2011 10:42

UNITED FIRE GROUP
Report to: Supervisor Roberta Sniffin

Transcriber: Edith McBurney
Date: 06-01-11

Claim No. **4001032727**
Insured: **Debbie Plucker**
Adjuster: **Sherri Wade**
Dictated Date: **05-26-11**
Adjuster Initials: *res 06/06/2011*

Supervisor Initials and Date through Image Right:

AUTO CAP REPORT

CONTACT DATE

05-25-11: Spoke with our insured and obtained her statement.
05-26-11: Left message for claimant to call.
05-26-11: Spoke with claimant carrier.

ENCLOSURES

1. Accident report from DOT.
2. Insured RS.
3. Blank Medical Authorization to insured.
4. Sub notice CC

COVERAGE

This loss was submitted under the insured's Personal Auto Policy PP0001 (06-98). Our insured has Medical Payments benefits subject to a $5,000 limit. Our insured also has Collision Coverage subject to a $500 deductible. However, currently, she is going through the other carrier for her vehicle. The policy period is 3/30/11 through 9/30/11.

DATE-TIME-PLACE

Date: 5/24/11
Time: 11:00 a.m.
Place: I-29 near Harrisburg, SD

DRIVER(S)

The insured driver is our named insured.

The other driver is Fred Finch who resides at 3712 North 7th Avenue, Sioux Falls, SD 57104. His phone number is 605-338-0870.

PASSENGER(S)

- Insured Vehicle

None

- Claimant Vehicle

None

FACTS

Our insured was northbound in the inside lane on I-35 traveling at approximately 65 mph. There was a semi also traveling northbound in the right lane at the time of the loss. The other party was southbound on I-29, and as they came near to the insured vehicle, the rear double tires came off the semi trailer, bounced across the highway, hit the semi that was to the right of the insured, bounced back and hit the front of the insured vehicle. Our insured had slammed on her brakes to try to avoid the loss, but could not turn to the right or the left due to the semis on both sides of her.

Our insured said that following the loss she did not feel like she was immediately injured, but a few hours later she started to have pain in her neck and shoulder.

WITNESSES

None known.

POLICE REPORT

We have a copy of the accident report in the file, and I have ordered another copy hoping to get a full narrative.

INJURED PERSON(S) BI-MP-UM-UIM

Our named insured states she has some pain in her neck and shoulder. She suffers from several diseases and illnesses that may affect her recovery. Her SSN is and DOB She receives Medicare benefits because she has been disabled since 1991. I have notified Medicare of this loss.

INDEX REPORT

PROPERTY DAMAGE

Unknown

COLLISION

Unknown

SALVAGE

None

LEGAL LIABILITY – Duty Owed, Duty Breached, Damages and Proximate Cause

The other party had a duty to have safe equipment on his semi. Because the company services and owns the semi, they are liable for this accident for unsafe equipment.

The insured has a statute of limitations of 5/24/14. She also has Medical Payments benefits for these three years.

CONTRIBUTION

None

SUBROGATION

We will subrogate against Liberty Mutual, and I have made contact with their adjuster. According to the adjuster, they have accepted liability and will not allow their insured to give us a statement.

FURTHER INVESTIGATION

Review police report when it comes in.

DEMANDS, OFFERS, SETTLEMENTS, FUTURE HANDLING

I sent the insured all of the forms to complete for her medical claim and will process these when they are returned.

ADVERSE CARRIER'S LIABILITY LIMITS

Unknown

RESERVE RECOMMENDATIONS

Verified in ACS today? ☒Yes ☐No Reserves Adequate? ☒Yes ☐No

Reserve amounts, analysis and recommendations:

Claimant #1Debbi Plucker:
MP: $1,250 reserved, $5,000 limit.
Reserves are good.

PICTURES

No

RISK ANALYSIS FORM NECESSARY?

No

AGENT ADVISED

Yes

NEXT REPORT DUE

60 days to 8/6/11

OTHER COMMENTS

UNITED FIRE & CASUALTY COMPANY
PO BOX 73909
CEDAR RAPIDS, IA 52407-3909
FAX 800-863-1703
PHONE 800-343-9131

MAY 25 2011

230299
BRENNER & JUSTICE INS INC
3701 W 49TH ST, STE 201
SIOUX FALLS, SD 57106

RE: Claim Number: 4001032727
Insured: PLUCKER DEBBIE
Ins. Driver: DEBBIE PLUCKER
Policy Number: 90625038
Date of Loss: 05-24-2011
Loss Location: I-29 N AT (MRM 071-63 + .108 HARRISBURG SD

Claimant: DEBBIE PLUCKER

We acknowledge receipt of the notice of loss for the above captioned claim. The adjuster assigned to this claim is:

SHERRI WADE
PO BOX 73909
CEDAR RAPIDS, IA 52407

Phone No: 319-399-5758
Branch Fax: 800-863-1703

The adjuster will make every effort to contact the insured and/or claimant promptly. Please direct any inquiries regarding this claim to the adjuster.

If you are unable to contact the adjuster and need immediate assistance please call the office as shown on this letterhead.

Sincerely,

UNITED FIRE & CASUALTY COMPANY
Claims Department

To: BRENNER JUDY MAE;
From: KHARRIS
Cc:
Bcc:
Subject: agent update for your file
Date/Time Sent: 2/21/2012 12:44 PM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

==========END OF MESSAGE==========

Attached Files:
IR110000.tif

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

emailed 2-21-12 kkh

FEBRUARY 21 2012

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re: Claim No.: 4001032727
Insured: PLUCKER DEBBIE
Date of Loss: 05/24/2011
Policy No.: 110 90625038

Reserves & Payments:

Total Payments Made To Date:	$	0.00
Remaining (Outstanding) Reserves:	$	1,250.00
Total Incurred:	$	1,259.50

Accident/Injury Description: A tire came off the clmt vehicle, bounced across the highway, hit another vehicle and came back to hit the insd vehicle.

Current Status: The insd has not submitted her med auth so I have not been able to assist her. It appears that she is going to settle with the other carrier directly but since that hasn't happened yet I leave the file open on a precautionary basis. I am going to follow-up with the other carrier in July and will update you at the same time as well.

If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

FEBRUARY 21 2012

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re: Claim No.: 4001032727
Insured: PLUCKER DEBBIE
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If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

To: BRENNER JUDY MAE;
From: KHARRIS
Cc:
Bcc:
Subject: agent update for your file
Date/Time Sent: 11/16/2011 3:00 PM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

==========END OF MESSAGE==========

Attached Files:
IR110000.tif

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

NOVEMBER 16 2011 emailed 11-16-11

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re: Claim No.: 4001032727
Insured: PLUCKER DEBBIE
Date of Loss: 05/24/2011
Policy No.: 110 90625038

Reserves & Payments:

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Accident/Injury Description: A tire came off the clmt vehicle, bounced across the highway, hit another vehicle and then hit the Insd vehicle.

Current Status: The insd has not ever sent her medical authorization to us so we have not handled her medical claim yet. As I understand it, the other carrier intends to pay these meds directly to the provider but I am leaving my file open until this is done. If the Insd decides to return the med auth, she can go through us yet.

If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

NOVEMBER 16 2011

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re: Claim No.: 4001032727
Insured: PLUCKER DEBBIE
Date of Loss: 05/24/2011
Policy No.: 110 90625038

Reserves & Payments:

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If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

To: BRENNER JUDY MAE;
From: KHARRIS
Cc:
Bcc:
Subject: agent update for your file
Date/Time Sent: 8/24/2011 10:16 AM

==========BEGINNING OF MESSAGE==========

Drawer: CLMS
FileNo: 4001032727

==========END OF MESSAGE==========

Attached Files:
IR110000.tif

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

emailed 8-24-11 kkh

AUGUST 24 2011

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re: Claim No.: 4001032727
Insured: PLUCKER DEBBIE
Date of Loss: 05/24/2011
Policy No.: 110 90625038

Reserves & Payments:

Total Payments Made To Date:	$	0.00
Remaining (Outstanding) Reserves:	$	1,250.00
Total Incurred:	$	1,259.50

Accident/Injury Description: A semi tire came off a semi in the opposing lane, crossed in front of the insd vehicle, bounced off the semi next to her and struck her vehicle.

Current Status: As you know the insd does not want to return the medical authorization so we have been unable to process her claim. Hopefully the insd will return this form soon.

If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds
Texas General Indemnity Company

AUGUST 24 2011

23-0299
BRENNER & JUSTICE INS INC
Email Delivery judy.brenner@midconetwork.com

CLAIM STATUS REPORT

Re: Claim No.: 4001032727
Insured: PLUCKER DEBBIE
Date of Loss: 05/24/2011
Policy No.: 110 90625038

Reserves & Payments:

Total Payments Made To Date:	$	0.00
Remaining (Outstanding) Reserves:	$	1,250.00
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Accident/Injury Description: A semi tire came off a semi in the opposing lane, crossed in front of the insd vehicle, bounced off the semi next to her and struck her vehicle.

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If you have any questions please contact this adjuster at: 319-399-5758

SHERRI WADE
CLAIMS REPRESENTATIVE TC

5/26/2011 11:11:09 AM - SWADE-Sherri Wade
CLMS - 4001032727
I left message for the other driver and the other carrier to call.

5/25/2011 4:22:28 PM - SWADE-Sherri Wade
CLMS - 4001032727
I obtained the insd's stmt.

5/25/2011 2:19:01 PM - SWADE-Sherri Wade
CLMS - 4001032727
I left the insd a message to call.

POSTED ON IRSERVER
05-25-2011 08:09:49 SCHEDL4 - Scheduler 4
CLMS - 4001032727

Claim Representative assigned to loss.

UNITED FIRE & CASUALTY COMPANY
PO BOX 73909
CEDAR RAPIDS, IA 52407-3909
FAX 800-863-1703
PHONE 800-343-9131

MAY 25 2011

230299
BRENNER & JUSTICE INS INC
3701 W 49TH ST, STE 201
SIOUX FALLS, SD 57106

RE: Claim Number: 4001032727
Insured: PLUCKER DEBBIE
Ins. Driver: DEBBIE PLUCKER
Policy Number: 90625038
Date of Loss: 05-24-2011
Loss Location: I-29 N AT (MRM 071-63 + .108 HARRISBURG SD

Claimant: DEBBIE PLUCKER

We acknowledge receipt of the notice of loss for the above captioned claim. The adjuster assigned to this claim is:

SHERRI WADE
PO BOX 73909
CEDAR RAPIDS, IA 52407

Phone No: 319-399-5758
Branch Fax: 800-863-1703

The adjuster will make every effort to contact the insured and/or claimant promptly. Please direct any inquiries regarding this claim to the adjuster.

If you are unable to contact the adjuster and need immediate assistance please call the office as shown on this letterhead.

Sincerely,

UNITED FIRE & CASUALTY COMPANY
Claims Department

07/05/2011 10:18 AM

MSPRC

Learn about your letter at www.msprc.info

CMS

July 1, 2011

2037 1 MB 0.390
***AUTO**MIXED AADC 720 R:2037 T:12 P:15 PC:5 F:8301
UNITED FIRE GROUP
PO BOX 73909
CEDAR RAPIDS, IA 52407-3909

Reviewed slg 07/05/2011 15:46

'4D201117500021754'

SUBJECT: Medicare Secondary Payer Rights and Responsibilities
Beneficiary Name: PLUCKER, DEBBIE L
Medicare Number:(
Case Identification Number: 201117409001096
Insurer Claim Number: NOT AVAILABLE
Insurer Policy Number: 4001032727
Date of Incident: May 24, 2011

Dear UNITED FIRE GROUP:

Please note that if we know that you have an attorney or other individual representing you in this matter, we are sending him/her a copy of this letter. If you have an attorney or other representative for this matter and his/her name is not at the end of this letter indicating that he/she is receiving a copy, please contact us immediately. If you have any questions regarding this letter and are represented by an attorney or other individual in this matter, you may wish to talk to your representative before contacting us.

We understand that you have made a claim against other insurance or workers' compensation. This letter is to let you know:

- What your responsibilities are as a Medicare beneficiary in connection with your claim;
- What information we need if you have a representative;
- What information we are requesting regarding your claim;
- What additional information you may receive on claims Medicare paid on your behalf on or after your date of incident;
- What information we need if there is a settlement, judgment, award or other payment for your claim (or if your claim is dismissed or otherwise abandoned).
- How to contact us (the MSPRC).

Your Responsibilities as a Medicare Beneficiary

- When no-fault insurance, liability insurance or workers' compensation is available to you, it must pay before Medicare pays. Some examples of no-fault and liability insurance include automobile or homeowners' medical payments coverage or personal injury protection, automobile liability or no-fault insurance, liability insurance which pays you because another individual or entity is negligent, malpractice insurance, etc.
- Medicare makes "conditional" payments while your insurance or workers' compensation claim is pending to ensure that you receive the medical services you need in a timely manner.
- Once you receive a settlement, judgment, award or other payment for your insurance or workers' compensation claim, Medicare will determine if it has a recovery claim which must be repaid to the Medicare program. If Medicare determines that it has a recovery claim, you will be provided with a demand letter, which will include applicable appeal and waiver of recovery rights. Medicare will not take any collection action during the pendency of any appeal or waiver request. (The applicable law can be found at 42 U.S.C. 1395y(b)(2)(A) & (B).)

Information We Need If You Have a Representative

If someone is acting as your representative (that is, an attorney or other individual who is acting on your behalf), you should have the following information sent to us so we can communicate directly with your representative as well as with you.

- If your representative is an attorney, he/she should send us a copy of the agreement you signed when you retained the attorney. The agreement should also be signed or countersigned and dated by the attorney; be on the attorney's letterhead (or have a cover letter from the attorney); and have your name and Medicare Health Insurance Claim Number (the number on your Medicare card) at the top of the document. This will act as proof that this attorney is representing you, may act on your behalf, and receive your Medicare claims information directly from us.
- If someone other than an attorney is your representative, you must send a letter that is signed and dated, telling us that he/she is your representative and the date of the incident or injury for which he/she is acting as your representative. Please include your name and Medicare Health Insurance Claim Number at the top of the letter so that we can easily associate your agreement with your file. Your representative must also sign and date the letter to show that he/she has agreed to represent you. (Model language for proof of representation is available on our website at www.msprc.info.)

As we stated at the beginning of this letter, if we have information that you have a representative, we are copying him/her on this letter. Your representative can take care of submitting this

information to us. (However, if your representative's name is not shown at the end of this letter, please give a copy of this letter to your representative.)

Information Requested Regarding Your Insurance or Workers' Compensation Claim

We are requesting that your representative send us the name, address, and telephone number of the insurer or workers' compensation carrier involved and, if available, the policy number, claim number, and claim adjuster's name. (If you do not have a representative, we ask that you send us this information.)

If we have a name and address for the insurer or workers' compensation, we are copying them on this letter. However, we may not have more specific information, such as the claims adjuster you are working with, so we are requesting that you send us the complete information.

4E2011175000021754

Information Regarding Claims Medicare Paid On Your Behalf on or After Your Date of Incident

Beneficiary representatives often ask us what "conditional" payments Medicare made on or after your date of incident. "Conditional" payments are those Medicare payments that are related to your pending insurance or workers' compensation claim.

Within sixty-five days from the date of this letter, you will receive a Conditional Payment Letter (CPL) which will show you the conditional payments Medicare has made on your behalf at that time, based upon the available information (an interim conditional payment amount). If you have an attorney or other representative, and we have appropriate proof of representation, we will also send a copy of this information to your representative. If we do not have the appropriate proof of representation, only you will receive the CPL; however upon receiving the appropriate proof of representation, a copy of the CPL will be forwarded to the authorized representative. (Please see the section above for information on appropriate proof of representation documentation.)

If your claim is for no-fault insurance or workers' compensation benefits, a copy of the CPL will be sent to the no-fault insurer or workers' compensation carrier if we have their information.

Please do not submit a request for a CPL because we will send one to you automatically as soon as the information is available. A separate request will not make the information available faster.

Once we send the CPL, we will also post this conditional payment information under the "MyMSP" tab of the www.mymedicare.gov website. The information at www.mymedicare.gov will be updated weekly with any newly processed claims. If you wish, you can also keep track of the medical expenses that were paid by Medicare, and if you have an attorney or other

representative, provide him/her with this information. This may assist him/her with finalizingyour settlement.

Information We Need If There Is a Settlement, Judgment, Award, or Other Payment (or If Your Claim Is Dismissed or Otherwise Abandoned)

Once you have a settlement, judgment, award, or other payment for your claim, if you have a representative, he/she should send us the following information. (If you do not have a representative, you will need to send us this information.)

- A copy of the settlement, judgment, award or other document regarding payment indicating the appropriate date and the total amount of the settlement, judgment, award or other payment.
- An itemized statement of attorney fees and other procurement costs that you are paying.

If settlement information is received by us prior to the CPL being issued to you, a Conditional Payment Notice (CPN) will be issued instead. The CPN gives you and/or your representative a specific timeframe to review and/or respond before the demand is issued.

If your claim has been dismissed or otherwise abandoned without a settlement, judgment, award, or other payment, please send us documentation of these actions so that we may close our record of this incident.

Mailing or Faxing Information to the MSPRC

Please use a copy of the enclosed "Correspondence Cover Sheet" whenever you or your representative submit any correspondence pertaining to the incident identified in the subject field of this letter. This cover sheet includes our address information and is pre-filled with information that will facilitate processing your correspondence. If you do not include a copy of this cover sheet, please include your name and your Medicare Health Insurance Claim Number (the number on your Medicare card) on all correspondence. This will allow us to associate the correspondence with the appropriate records.

MSPRC

Learn about your letter at www.msprc.info

CMS

Attached is a Privacy Act Statement that explains your privacy rights. You may be interested in the enclosed brochure about the MSPRC and the recovery process.

Sincerely,

MSP Recovery Contractor

Enclosures:
Privacy Statement
Medicare Secondary Payer Recovery Contractor Brochure
Correspondence Cover Sheet

CC: DEBBIE L PLUCKER

4F2011175000021754

MSPRC

Learn about your letter at www.msprc.info

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

NOTICE TO BENEFICIARY ABOUT THE COLLECTION AND USE OF MEDICARE INFORMATION (PRIVACY ACT STATEMENT)

The Social Security Act mandates the collection of this information. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information collected may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of Title XVIII; and to an individual or organization for a research evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

4G20111750002175A

The identification number we are using is your Medicare Health Insurance Number. While furnishing the information on this form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records.

Public Law 100-503, the computer Matching and privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Anyone who knowingly and willfullymakes, or causes to be made, a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both.

According to the paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information is 0938-0214. The time required to complete this information collection is estimated to average 5 minutes per responder, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

07/05/2011 10:18 AM

MSPRC

Learn about your letter at www.msprc.info

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Correspondence Cover Sheet

Beneficiary's Name: PLUCKER, DEBBIE L
Medicare Number:
Date of Incident: May 24, 2011
Case Identification Number: 201117409001096
Insurer Policy Number: 4001032727
Insurer Claim Number: NOT AVAILABLE

8H201117500021754

This cover sheet is for your use when mailing or faxing in correspondence to the MSPRC. Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the MSPRC to facilitate routing. Check all that apply:

- ☐ Check
- ☐ Settlement information
- ☐ Retainer agreement or other authorization documentation
- ☐ Other _____

Note: A Conditional Payment Letter is sent automatically within 65 days of this letter, or as soon as the information is available. **Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.**

In order to accurately associate claims to your case, please include a description of the injury. (i.e.: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

_____
_____
_____
_____

Submit correspondence to the MSPRC address listed below:

Liability Insurance or No Fault Insurance Workers' Compensation:

Medicare Secondary Payer Recovery Contractor
PO BOX 138832
OKLAHOMA CITY, OK 73113
1-405-869-3309

07/05/2011 08:52 AM

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

COB
MEDICARE - Coordination of Benefits
1-800-999-1118 or (TTY/TDD): 1-800-318-8782

****FIRST CLASS MAIL- R:7510 T: P: F:53099 June 27, 2011
UNITED FIRE GROUP
PO BOX 73309
CEDAR RAPIDS IA 52407-3909

0075100007510

4547878726 7A__0018_

DEAR UNITED FIRE GROUP:

RE: Beneficiary Name: DEBBIE L PLUCKER
HIC#:
Policyholder/Subscriber Name:
Policy/Claim Number: 4001032727
Date of Illness/Injury:
Check Date:
Check Number:
Check Amount: $0.00

Medicare received a voluntary refund and/or information indicating that you have primary payment responsibility for medical services provided to the beneficiary noted above. The refund and/or information received contains insufficient information, therefore Medicare is unable to properly update its internal records and adjust any previously paid claims. ***A response is necessary within 10 days.***

In order to accurately update our records, please call our toll free customer service line at: 1-800-999-1118 or 1-800-318-8782 for the hearing impaired or complete the enclosed questionnaire and return it in the enclosed courtesy reply envelope. Failure to respond timely could result in the incorrect payment of your medical claims.

Enclosure: Questionnaire

Continued...

07/05/2011 08:52 AM

NOTICE TO PATIENT ABOUT THE COLLECTION
AND USE OF MEDICARE INFORMATION
(PRIVACY ACT STATEMENT)

The Social Security Act mandates the collection of this information. The purpose of collecting this information is to properly pay medical insurance benefits to you or on your behalf.

Information collected may be given to health insurance providers and suppliers of services (and their authorized billing agents) directly or through fiscal intermediaries or carriers, for administration of title XVIII; and to an individual or organization for a research evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration or maintenance of health.

The identification number we are using is your Medicare Health Insurance Number. While furnishing the information on this form is voluntary, the Medicare program may not be able to make accurate claims payment when the requested information is not available in its records.

Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988 permits the government to verify information by way of computer matches. Anyone who knowingly and willfully makes or causes to be made a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment, or both.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0214. The time required to complete this information collection is estimated to average 5 minutes per responder, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

COMPLETED QUESTIONNAIRES SHOULD BE RETURNED TO THE BELOW ADDRESS, USING THE ENCLOSED ENVELOPE:

MEDICARE-COORDINATION OF BENEFITS CONTRACTOR
MSP Claims Investigation Project
PO BOX 33847
DETROIT, MI 48232-5847

07/05/2011 08:52 AM

MEDICARE SECONDARY PAYER DEVELOPMENT

NAME	MEDICARE HEALTH INSURANCE CLAIM NUMBER
DEBBIE L PLUCKER	

INSTRUCTIONS: This form will be read by a computer. Please print as shown below. Stay within the boxes. Use CAPITAL letters. Mark boxes with an X. **USE BLACK OR BLUE INK.**

EXAMPLE [| A | B | C | | | 1 | 2 | 3 | | |]

SECTION A - INFORMATION ABOUT YOU

1) Do YOU have any group health plan coverage based upon your current employment?
YES ☐ NO ☐ (If NO, go to SECTION B)

2) How many employees, including yourself, work for the employer from whom you have health insurance?
Don't Know ☐ 1-19 ☐ 20-99 ☐ 100 or More ☐ (If less than 20, go to SECTION B)

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

DATE INSURANCE COVERAGE BEGAN (M M – D D – Y Y Y Y) POLICY NUMBER

TYPE OF INSURANCE: HOSPITAL/MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY (DOCTOR/SUPPLIER) ☐

3) Does your group health plan cover prescription drugs? YES ☐ NO ☐ (If NO, go to SECTION B)
Please use your insurance card to provide the following information if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

SECTION B - INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER

1) Do YOU have any group health plan coverage based upon your spouse's/other family member's current employment? YES ☐ NO ☐ (if NO, go to SECTION C)

2) How many employees, including your spouse/other family member, work for the employer from whom they have health insurance? Don't Know ☐ 1-19 ☐ 20-99 ☐ 100 or more ☐
(If less than 20, go to SECTION C)

OMB # 0938-0214

(TURN PAGE OVER)

MSP053099:MSPA1F:06/27/2011

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07/05/2011 08:52 AM

SECTION B - INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER, CONTINUED

Policy Holder/Subscriber's First Name

Policy Holder/Subscriber's Social Security Number

Policy Holder/Subscriber's Last Name

Please provide information about the employer and the employer group health plan in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF GROUP HEALTH PLAN

ADDRESS

ADDRESS

CITY STATE ZIP

DATE INSURANCE COVERAGE BEGAN (M M – D D – Y Y Y Y) POLICY NUMBER

TYPE OF INSURANCE: HOSPITAL/MEDICAL ☐ HOSPITAL ONLY ☐ MEDICAL ONLY (DOCTOR/SUPPLIER) ☐

3) Does your family member/spouse's group health plan cover prescription drugs?

YES ☐ NO ☐ (If NO, STOP, go to SECTION C)

Please use your insurance card to provide the following information, if available:

Rx GROUP Rx PCN

MEMBER ID Rx BIN

SECTION C - MORE INFORMATION ABOUT YOU

1) Are YOU receiving Black Lung Benefits? YES ☐ NO ☐

2) Are YOU receiving Workers' Compensation benefits? YES ☐ NO ☐

3) Are YOU receiving treatment for an injury or illness which another party could be held liable or could be covered under no-fault or auto insurance? YES ☐ NO ☐

STOP If YOU answered YES to any questions in this section, go to SECTION D
If YOU answered NO to all of these questions, sign below and return this form only.

Your Signature

AREA CODE PHONE NUMBER

OMB # 0938-0214

(CONTINUED ON NEXT PAGE)

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07/05/2011 08:52 AM

MEDICARE SECONDARY PAYER DEVELOPMENT, CONTINUED

NAME	MEDICARE HEALTH INSURANCE CLAIM NUMBER
DEBBIE L PLUCKER	478787267A

SECTION D - MORE INFORMATION ABOUT YOU

1) If YOU are getting Black Lung (Coal Miner's) Medical Benefits, print the date the benefits began.

M M – D D – Y Y Y Y

2) If YOU are now receiving any medical services related to an illness or injury which occurred on the job, for which YOU have or will file a Workers' Compensation claim, print the date of illness or injury.

M M – D D – Y Y Y Y

Please provide information about the employer and the employer, insurance carrier, and attorney in the spaces below:

EMPLOYER NAME

ADDRESS

ADDRESS

CITY STATE ZIP

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

CU478787267A_001/_

00751000751O

OMB # 0938-0214

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MSP053099:MSPA3F:06/27/2011

07/05/2011 08:52 AM

SECTION D - MORE INFORMATION ABOUT YOU, CONTINUED

3) If YOU are now getting any treatment for an illness or injury for which another party could be held liable, please print the date of illness or injury: M M – D D – Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

4) If YOU are now getting any treatment for an illness or injury which could be covered under no-fault or automobile insurance, print the date the of illness or injury: M M – D D – Y Y Y Y

NAME OF INSURANCE CARRIER

ADDRESS

ADDRESS

CITY STATE ZIP

POLICY or CLAIM NUMBER

NAME OF ATTORNEY (If Applicable)

ADDRESS

ADDRESS

CITY STATE ZIP

BRIEF DESCRIPTION OF ILLNESS OR INJURY

Your Signature

AREA CODE – PHONE NUMBER

OMB # 0938-0214

UF000060

00751000751O

May 26, 2011

Medicare Coordination of Benefits
PO Box 33847
Detroit, MI 48232

RE: HIC#:
BENFICIARY: Debbie Plucker
INCIDENT DATE: 5/24/11
INSURED: Debbie Plucker
OUR CLAIM #: 4001032727

To whom it may concern:

Please accept this letter as your report of this incident:

BENEFICIARY ADDRESS: 45730 SD Highway 44, Parker, SD 57053
DOB:
TYPE OF INCIDENT: Motor Vehicle Accident
LOCATION OF INCIDENT: I-29, Harrisburg, SD
INJURY: Soft tissue – neck & shoulder
EMPLOYER COVERAGE: N/A
ATTORNEY: N/A
BLACK LUNG: Unknown
WORK COMP: N/A

If you have any questions, please feel free to call us at 319-399-5758. Our normal office hours are Monday through Friday from 8:00am until 4:30pm.

Sincerely,

Sherri Wade, Claims Representative

To: New Claims <newclaims@unitedfiregroup.com>
From: "messaging@concordfax.com" <messaging@concordfax.com>
Date: Mon, 20 Jun 2011 07:25:09 -0500
Subject: New 3 pages fax message from 16786946000, LexisNexis

You have received a 3 pages fax at your fax number 18885149190.

The fax was received at 2011/06/20 07:23:23.

Thank you for using Concord Fax Online.

www.concordfax.com

Purpose of use:	Personal
Was vehicle used with permission?	Yes
Was driver injured?	[redacted]
Injury description:	[redacted]

[redacted]

Property Description:	1991 Freightliner (we didn't damage it- it damaged us)
Is property a vehicle?	Yes
Is property insured?	Yes
Other Carrier:	?
Policy Number:	ATJZ91453456051
Damage Description:	don't know
Where can damage be seen?	don't know
Estimate Amount:	

Owner:	Dakotaland, Inc.
Address:	PO Box 84038 Sioux Falls, SD 57118
Phone:	

Driver:	Frederick Finch
Address:	3712 N 7th Ave Sioux Falls, SD 57104
Phone:	H: (605)338-0870

[redacted]

[redacted]

[redacted]

Plucker.pdf

[redacted]

***Reported By:** Insured
Previously Reported: NO
***Completed By:** KATHRYN E JUSTICE - KATHY.JUSTICE@MIDCONETWORK.COM

Remarks: Insured has filed claim with Dakotaland, Inc. for her vehicle. (The location of the accident is correct mile marker # but the city probably is not. Your system required me to put one in but there isn't one on the HP report and they weren't at a city).

KHARRIS - A

4001032727

UNITED FIRE GROUP

Auto Loss Report

Policy Number: 90625038
Account Number: 237798
Loss Date: 05/24/2011 11:00 AM

Reference Number: 26106
Agency: - 230299
Reported Date: 05/24/2011
Completed Date: 05/24/2011 4:38 PM

INSURED

***Name:** PLUCKER DEBBIE
***Address:** 45730 SD HIGHWAY 44
PARKER, SD 57053
Email: dvplucker@aol.com

***Phone:** O: (605)728-5595
Location Code:
Marital Status: Married
Birth Date:

CONTACT

Name:
Address: 45730 SD HIGHWAY 44
PARKER, SD 57053
Email: dvplucker@aol.com

Phone: O: (605)728-5595
Where to Contact:
When to Contact:

LOSS

***Location:** I-29 N at (MRM 071-63 + .108
Harrisburg, SD 57032
***Loss Type:** PIP/MEDICAL/INCOME CLAIM ONLY
Authority Contacted: SDHP
Violations/Citations: Unknown

Loss Time: 11:00 AM
Report Number:

Description: A semi tractor/trailer rig lost both rear tandems which hit the semi that wasin front of the insured and then bounced off that truck and hit our insured.

INSURED VEHICLES

Veh #	Year	Make	Model	Body	VIN	State Plate
14	2011	CHEVROLET	SILVERADO C1500 LT		1GCRCSE07BZ331885	

Owner: Same As Insured
Address:

Phone:
Email:

Estimate Amount:
Where can vehicle be seen?
When can vehicle be seen?
Damage Description:
Other Insurance:

see next page

INSURED DRIVER

***Name:** DEBBIE PLUCKER
Address: 45730 SD HIGHWAY 44
PARKER, SD 57053
Email: dvplucker@aol.com

Phone: O: (605)728-5595
Relation to Insured: Insured
Birthdate:
License Number: 00588887
License State: SD

REPORT ATTACHED

PAGE COUNT: 3

CLIENT : 3182
DIVISION : 0001
ADJUSTER : XCAE3P
CLAIM : 4001032727(COLL)

TRANSACTION # : 355571301
DATE : 06/17/2011

DATE OF LOSS : 05/24/2011 TIME OF LOSS :
STREET : I29 N
CITY : HARRISBURG
COUNTY : LINCOLN
STATE : SD

INVESTIGATING AGENCY : SD HP
REPORT NUMBER :
REPORT TYPE : Auto Accident
PARTY 1 : DEBBIE PLUCKER
PARTY 2 : FREDERICK FINCH
PARTY 3 :

CAR : MAKE : YEAR :
TAG :

DRIVER LICENSE :
ADDITIONAL INFO :
ALSO ASK FOR THE NARRATIVE ON THE POLICE REPORT

POLICY #:
POLICY STATE:
LOSS KIND:

NOTE :

THANK YOU FOR YOUR ORDER!

Auto Accident Confirmation

Thank You for Your Order!

Order Date 12:13:55 EDT - Thursday May 26, 2011

Back to Order Form
Order a Different Report Type Using the Current Data

Claim #:	4001032727(coll)
Adjuster ID:	XCAE3P
Division Account:	AAK 0001
Report Type:	Auto Accident
Loss Date:	05/24/2011
Time:	
Street:	I29 N
Cross Street:	close to mile marker 71-63
City:	Harrisburg
State:	sd
Zip:	
County:	LINCOLN
1st Party/Driver:	Plucker Debbie
Driver License #:	
License State:	
Birth Date:	
SSN:	
VIN:	
2nd Party Involved:	Finch Frederick
3rd Party Involved:	
Vehicle Tag #:	
Tag State:	
Vehicle Year:	
Vehicle Make:	
Vehicle Model:	
Agency Name:	South Dakota Highway Patrol
Agency Type:	HP
Report #:	
Precinct:	

[redacted]

Reviewed slg 06/20/2011 09:07

1106470 05/24/2011 11:00:00AM City - Rural LINCOLN County
NICK C JENSEN - South Dakota Highway Patrol Photos not taken

On I 29 N at (MRM 071.63 + .105)
Road: I 29 N MRM: 0.00 Non-junction
Nearest crossing: 0.37 Miles N of 273 ST
Intersection:
Latitude: 43.437313 Longitude: -96.798412

FHE: Motor vehicle in transport
FHE Loc: On roadway
Road Cond: Dry
Surface Type: Concrete
Trafficway: Two-way, divided, unprotected (painted >4 feet) median
Road Alignment: Straight and level
Manner of Collision: Angle
Lighting: Daylight
School bus related: No (school bus not involved)

Work zone related: No
Workers present: No
Work zone locati: Not applicable
Work zone type: Not applicable

Weather
Clear

Unit: 1 2011 CHEV SILVER Plate: 61GB20 Plate State: SD

Owner: PLUCKER, DEBBIE LYNN
45730 SD HWY 44
PARKER, SD 570538824

Unit type: Motor vehicle in transport with driver
Cargo body: No cargo body
VIN: 1GCRCSE07BZ331885
Maneuver: Straight ahead
Hit and run: No
Initial point of Impact: Front
Damage extent: Minor damage
Traffic device: No controls
MHE: Motor vehicle in transport
Damage Amt: $2,000.00
Trailer: No trailer/attachment
Travel Dir: Northbound
Insurance: UNITED FIRE AND CASUALTY CO
Effective: 03/30/2011

Occupants: 1
Veh config: Light truck (2 axles, 4 tires)
Vehicle towed: No
Most damaged area: Front
Underride/override: None - no underride or override
Vision Contrib: None
Veh Contrib: None
Road Contrib: None
Est Speed: 75 Driver statement Speed Limit: 75
Policy: 011080625036
Expiration: 09/30/2011

Events
Motor vehicle in transport

Unit: 2 1991 FRET TT Plate: 66275C Plate State: SD

Owner: DAKOTALAND TRANS INC,
PO BOX 84035
SIOUX FALLS, SD 57118

Unit type: Motor vehicle in transport with driver
Cargo body: Van/enclosed box
VIN: 1FUYDXYB0MP396183
Maneuver: Straight ahead
Hit and run: No
Initial point of Impact: Rear
Damage extent: Functional damage
Traffic device: No controls
MHE: Motor vehicle in transport
Damage Amt: 5500.00
Trailer: Semi-trailer/double/triple
Travel Dir: Southbound
Insurance: LIBERTY MUTUAL INS CO
Effective: 01/01/2011

Occupants: 1
Veh config: Tractor/semi-trailer
Vehicle towed: No
Most damaged area: Rear
Underride/override: None - no underride or override
Vision Contrib: None
Veh Contrib: Tires
Road Contrib: None
Est Speed: 45 Driver statement Speed Limit: 75
Policy: ATJZ91453456051
Expiration: 01/01/2012

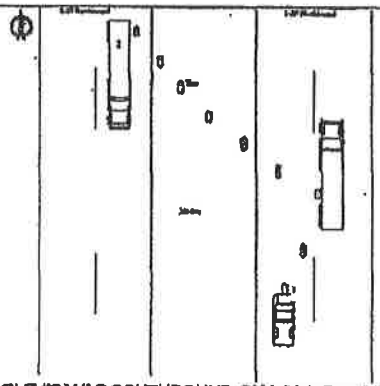
Carrier: 88 DAKOTALAND TRANSPORTATION INC
PO BOX 84038
SIOUX FALLS SD 57118
Haz mat released: Not reported GVWR: 0 GCWR: 0

Events

Equipment failure (tires, brakes, etc.)	Motor vehicle in transport

Unit 1 FLUCKER, DEBBIE LYNN		Female
45750 SD HWY 44	No injury	Not transported
PARKER SD 570535624	DL Class: Car/truck/motorcycle	DL Status: Normal, w/n restrictions
DL: SD *****8887	Phone: (605) 728-5595	
Age: 51	DOB: 09/05/1[redacted] NO CITATIONS	
Airbag: Not deployed	Ejection: Not ejected	
Seating: Operator	Safety Equip: Lap belt and shoulder harness used	
No drug use	No alcohol use	
Drug test refused	Test not given	
Driver Contrib	Nonmot Contrib	
None		
Unit 2 FINCH, FREDERICK ALBERT		Male
3712 N 7TH AVE	No injury	Not transported
SIOUX FALLS SD 571040733	DL Class: A3	DL Status: Normal, w/n restrictions
DL: SD *****7712	Phone: (605) 338-0870	
Age: 71	DOB: [redacted]	
Airbag: Not deployed	Ejection: Not ejected	
Seating: Operator	Safety Equip: Lap belt and shoulder harness used	
No drug use	No alcohol use	
Drug test not given	Test not given	
Driver Contrib	Nonmot Contrib	
None		
Other		

Unit 2 FINCH, FREDERICK ALBERT
32-15-18 Droping, sifting, or leaking load.



VEHICLE #2 WAS SOUTHBOUND ON I-29 NEAR MP 71. VEHICLE #1 WAS NORTHBOUND ON I-29 NEAR MP 71. THE TIRES ON THE REAR AXLE OF VEHICLE #2'S TRAILER CAME OFF AND CROSSED THE MEDIAN. ONE OF THE TIRES CROSSED INTO THE NORTHBOUND LANE WHERE IT WAS RUN OVER BY A NORTHBOUND TRACTOR TRAILER. THE TIRE WAS KICKED UP BY THE TRACTOR TRAILER THEN THE TIRE STRUCK VEHICLE #1. IT WAS LATER DISCOVERED THE REAR AXLE OF VEHICLE #2'S TRAILER WAS JUST REPLACE 1/2 HOUR BEFORE THE CRASH. THE MECHANIC ADMITTED THAT HE MUST HAVE FORGOT TO TIGHTEN THE LUG NUTS.

DRIVER INFORMATION EXCHANGE (1)

Investigating Agency	Officer Last Name	Officer First Name	Date of Crash (2)	Time of Crash
SOUTH DAKOTA HIGHWAY PATROL	JENSEN	NICK	06/24/2011	11:00

County	City	Location Description
42 - LINCOLN	0000	ON I 29 N AT (MRM 071.63 + .108)

UNIT 001

Driver Last Name (3)	Driver First Name	Street Address	Phone
PLUCKER	DEBBIE	45730 SD HWY 44	6057285595

City	State	Zip Code	Date Of Birth	Driver License Number (4)	State
PARKER	SD	570536624		00588887	

Vehicle Owner Last Name	Owner First Name	Street Address	Phone
PLUCKER	DEBBIE	45730 SD HWY 44	

City	State	Zip Code	Vehicle Make	Vehicle Model	Vehicle Color	Year
PARKER	SD	570536624	CHEV	SILVER		2011

Vehicle License	Insured By	Policy Number
61GB20	13021 - UNITED FIRE AND CASUALTY CO	011090625038

UNIT 002

Driver Last Name (3)	Driver First Name	Street Address	Phone
FINCH	FREDERICK	3712 N 7TH AVE	6053380870

City	State	Zip Code	Date Of Birth	Driver License Number (4)	State
SIOUX FALLS	SD	671040733		00807712	SD

Vehicle Owner Last Name	Owner First Name	Street Address	Phone
ING	DAKOTALAND	PO BOX 84038	

City	State	Zip Code	Vehicle Make	Vehicle Model	Vehicle Color	Year
SIOUX FALLS	SD	57118	FRET	TT		1991

Vehicle License	Insured By	Policy Number
68275C	23043 - LIBERTY MUTUAL INS CO	ATJZ91453456051

For a Copy of Your Accident Report

Department of Public Safety - Office of Accident Records - 118 West Capitol Avenue - Pierre, SD - 57501

Enclose $4.00 Check or Money Order, Driver Name, Date of Crash and County. Allow 3-4 Weeks for Return!

Accident Records 605.773.3668 SDHP Sioux Falls 605.367.5700 - Aberdeen 605.626.2286 - Rapid City 605.394.2286

(1) SDCL 32-34-13 – "Reports pursuant to SDCL 32-34-7 to 32-34-12, inclusive, and the information contained in such reports is not privileged and may not be held confidential. The [State of South Dakota] shall collect four dollars for each request to locate a report on file".

(2) SDCL 32-34-7 – "The driver of any motor vehicle involved in an accident resulting in bodily injuries or death to any person or property damage to an apparent extent of one thousand dollars or more to any one person's property or two thousand dollars per accident shall immediately, by the quickest means of communication, give notice to the nearest available law enforcement officer who has jurisdiction."

(3) SDCL 32-12-81 – "... The [State of South Dakota] shall maintain records or make suitable notations on the individual record of each licensee showing the convictions of such licensee and the traffic accidents in which the licensee has been involved... ."

(4) 18 U.S.C. SECTION 2721 (a) – "... A State department of motor vehicles, and any officer, employee, or contractor, thereof, shall not knowingly disclose or otherwise make available to any person or entity ... (2) ... highly personal information ... without the express consent of the person to whom such information applies... ."

June 6, 2011

Liberty Mutual
Derron Lax
PO Box 168328
Irving, TX 75016

RE:	Our Claim No.	4001032727
	Our Insured:	Debbie Plucker
	Date of Loss :	5/24/11
	Location:	I-29, Harrisburg, SD
	Your Policy/Claim No.	AB961-070925
	Your Insured:	Dakotaland Inc, Driver: Fred Finch

The above described accident caused damage(s) to property owned by our insured, or personal injuries, as evidenced by the enclosed bills or estimates. Our investigation of the accident discloses it was caused by the negligence of your insured. We have not completed settlement of this claim as of this date. Final settlement figures will be furnished at time of final payment.

In order to assist you in evaluating and processing the subrogation claim we are asserting, we may provide nonpublic personal information about our customer. We are sharing this information to effect, administer, or enforce a transaction authorized by the consumer. However, you are neither authorized nor permitted to: (1) use the customer information we provide for any purpose other than to evaluate and process the subrogation claim, or (2) disclose or share the customer information we provide for any purpose other than to evaluate and process the subrogation claim.

Thank you.
UNITED FIRE AND CASUALTY COMPANY

Sherri Wade, Claims Representative
Claims Department

319-399-5758

Enclosures

05/26/2011 01:01 PM

Claim No. H01032727 **RECORDED STATEMENT RESUME**

Interviewer: SWade

Recorded Phone on 5/25/11

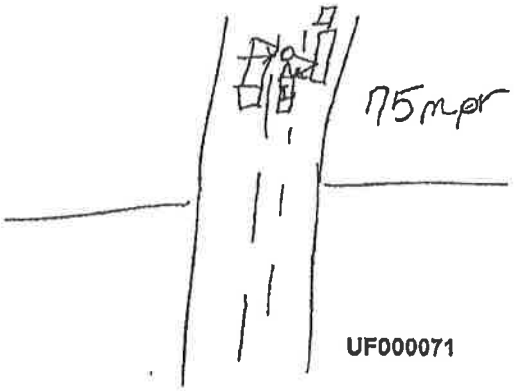
Recorded Statement of ~~Claimant~~ Deb Rucker

Name:	Address: 45730 57053	Phone No.: Cell 605-728-5595
DOB:	SSN:	Citizen: Y
Medicare: (A)	HICN No.:	
SSDI: Disability	End Stage Ren: N	ALS: N
Injured: N/A	If yes, explain:	

Subject Data & Comments:
1991 – vision, heart disease, thyroid, conj.

RESUME

2001 Silverado R/O
5/24/11 11AM I-29 NB by Sioux Falls
in passing lane passing CV – wheel hub tire
came sailing across
front end of mod veh – right in middle
braked as hard as she could
fish tailed – 30ft.
45mpr C
airbags D
D seat belt tightened
Wearing seat belt



CD1027B(10/14/2010)

UF000071

05/26/2011 01:01 PM

2 hrs afterwards - stiffin in neck & right shoulder

Robin Lapher - Chiropractic
Sioux Falls } alot of pain

fibromyalgia: as needed

not much feed back - appt next Tues

Semi driver came down walked down to see if OK - minimal

from Canada

came off axel both came off

rear off back of semi trailer

s/w

estimate on veh.?

citations: unknown

Claim #

Derron Lak

897-884-1977

K 3845

Claim # AB961-070925

Liberty Mutal

Q. This is Sherri Wade with United Fire Group, and I am interviewing Deb Plucker over the telephone on Wednesday, May 25th, of 2011 at approximately 2:30 p.m. This concerns an accident that happened on May 24th, 2011 near Harrisburg, South Dakota. Deb, I am with your insuranoe oompany, and Deb, would you please state your full name and spell out your last name?

A. Debbie _____ P-L-U-C-K-E-R.

Q. And is this recording being made with your full knowledge and consent? Is this recording being made with your full knowledge and consent, Deb?

A. I said yes.

Q. Oh, sorry.

A. That's okay.

Q. What is your current home address?

A. 45730 South Dakota Highway 44, Parker, South Dakota 57053.

Q. And what's t he best phone number to reach you at?

A. 605-728-5595.

Q. And is that a home number, cell number?

A. It's a cell number.

Q. Your date of birth?

A. Date of birth,

Q. And your social security number?

A.

Q. I'm sorry. Can you slow down a little bit, Deb. Can you tell me _____?

A. I though we were just being recorded. I didn't know you were documenting.

Q. A little bit of both. WE are being recorded, but I'm also documenting so I can.

A. Okay dokey.

Q. Okay. Go ahead. What's your social security number again?

A.

Q. And are you a United States citizen?

A. Yes, I am.

Q. And do you qualify for any Medicare or Medicaid benefits?

A. Yes, I do.

Q. And which of those do you qualify for?

A. Medicare disability.

Q. And how long have you been on disability?

A. I believe since '91.

Q. And what is that for?

A. Um it's several different things put together, several different physical problems.

Q. Okay and can you describe that a little bit for me?

A. Mm all the way from _____ to musculoskeletal to heart disease to fibromyalgia to thyroid problems to bilateral calcaneal fractures to congenital deformations.

Q. And is there one issue that has caused these problems for you?

A. No, not altogether. They're just several different things.

Q. Okay. And do you have a number that - that the disability benefits come under? Like I know with Medicare, they either get Part A or Part B so their member number is like the social security number plus an A or a B.

A. Plus A.

Q. Plus A. Okay. And do you have any end stage renal disease?

A. No, I do not.

Q. Lou Gehrig's?

A. No, I do not.

Q. And what vehicle were you driving at the time of the accident?

A. A 2011 Silverado.

Q. And are you the registered owner of this vehicle?

A. Yes, I am.

Q. And I have the date of the accident as May 24th, 2011. Does that sound correct to you?

A. Yes, it is.

Q. And about what time of day did that happen?

A. Uh the highway patrol states on his report it was 11:00 a.m.

Q. And where were you at exactly?

A. Um I-29 northbound south of Sioux Falls near the Harrisburg exit.

Q. And what direction were you going?

A. Northbound.

Q. And how many lanes are there northbound on that highway?

A. Other than the exit which is real close by, there are two ongoing lanes.

Q. And were you in the inside or the outside lane?

A. I was in the passing lane which would be the inside lane.

Q. And in your own words can you tell me what happened?

A. Um I was in the passing lane passing a semi tractor trailer. I was probably – the front end of my vehicle was probably equivalent to being real close to the back end of his trailer, and as I was passing him, um a wheel, an entire wheel, hub tire, I mean the rim and the tire came sailing across from the west across the median down to the grass, full in front of me, hit the semi to my right that I was passing, hit the trailer and slammed into me as it deflected off of his trailer.

Q. And what part of your vehicle was damaged?

A. The front end.

Q. And is it more towards the passenger side?

A. No, it's actually almost right in the middle.

Q. And what happened after that wheel hit your vehicle?

A. Well, I automatically braked. I braked as hard as I could uh thinking I could let it go. I mean you try to think that it's gonna deflect off of the trailer and quickly get into the ditch, but I didn't have the time, and I was boxed in with the trailer being next to me on one side and the ditch being on the other. Uh I braked as hard as I could. All the belongings in my vehicle, my purse and everything, flew far forward and I fishtailed. I felt my vehicle fishtail as I was slamming on the brakes, and the patrol officer and I looked, and we could see where I braked for at least a good 30 feet.

Q. And so you stayed in your lane then?

A. Stayed in my lane, and I started to pull towards the ditch, but I obviously didn't want to go in the ditch.

Q. And what's the speed limit in that area?

A. I believe it's 75. I think I was going right around 65 miles an hour.

Q. And did your airbags deploy?

A. Did not.

Q. And did you seatbelt tighten?

A. Did not.

Q. And were you wearing your seatbelt?

A. Yes, I was.

Q. And were you injured in the accident?

A. I believe so. I didn't think so immediately, but about two hours afterwards I started to feel the stiffening in my neck and in my right shoulder, and I had such a terrible, terrible headache. It was just – it was just progressive until this morning. I went to the doctor, and we're starting to treat now.

Q. And what doctor did you go to?

A. The name is Robin R-O-B-I-N Lanpher L-A-N-P-H-E-R.

Q. And is that a chiropractor or medical doctor?

A. _____ chiropractic.

Q. And are – is he right there in Parker?

A. No, he's in Sioux Falls.

Q. And do you normally see a chiropractor there?

A. Yes, I do.

Q. And what do you normally treat for?

A. Just various little problems. I have fibromyalgia, so whenever it happens to be the problem at the time is what we treat.

Q. So do you see him on a regular basis, or as an as needed basis?

A. Needed – it could be months, or it could be a couple times, and then I'm good for awhile.

Q. Okay. And what did he tell you today when you went in?

A. I think we just did an evaluation. I didn't get much feedback from him.

Q. Did he give you some kind of treatment plan?

A. I need to see him; not as far as a plan, um I do have an appointment next Tuesday in the afternoon.

Q. And after the accident, did you speak with the semi driver that lost the wheel?

A. Yes, I did. He actually came down and because there was an _____ on each side of the road – on the interstate right there, the Harrisburg exit, he approached up to the top of his exit going southbound, walked down and did come across the traffic lane onto the southbound lane just to I guess probably to see if I was okay.

Q. And do you remember the extent of your conversation? Did he say anything about the wheel?

A. No, it was just minimal. I mean everybody knows that you don't say a lot in a conversation like that ya know it's everybody is high strung, don't know what happened and ya know just basically just making sure that the other party was – was gonna be all right.

Q. And did the semi that you were initially passing, did that truck stop, or did it keep going?

A. It stopped, but the patrol officer let it go. It was, I believe, from Manitoba, Canada.

Q. Okay. And the wheel that came off, did it come off of the axle, or was it like a spare wheel that was somewhere else on the truck?

A. No, it came off of the axle and both of them were missing; one landed behind the tractor trailer going southbound and the west side of the ditch, and the other one came across the median.

Q. And was it then the rear tires off of the semi trailer, or was it _____ trailer or on the semi?

A. The rear two tires back – there's tandems. There was the back set closest to the rear end of the trailer on the driver side.

Q. And have you spoken with the other insurance company at all?

A. I did this morning, yes.

Q. And what did they tell ya?

A. They told me uh they just got general information. They didn't really ask. They asked what happened basically told me the exact same thing that I'm telling you. Uh they wondered if I had an estimate on my vehicle. I said yes I had. It was already a pre-authorized person that they deal with I guess on a constant basis, and I did let them know that I was going to see a doctor today.

Q. Okay so they're gonna take care of the damages to your car?

A. That is my understanding.

Q. Okay. And do you know? Did the police issue any citations to anyone?

A. I don't know. I don't know. That would be a good question to be answered for myself as well. I have no idea. None to me. I can state that, none to me.

Q. Okay. All right. Are there any other facts about this, Deb, that I haven't asked you that you'd like to add for the statement?

A. I don't think so other than I'm in a lot of pain, and it's too bad it had to happen, and I wish things would just be better.

Q. Okay. Have you understood all of my questions?

A. I think I have.

Q. Have all of your answers been true and correct to the best of your knowledge?

A. Yes, they have.

Q. And once again, did I have your full knowledge and consent in obtaining this recorded statement?

A. Yes, you have.

Q. Okay. I'm gonna go ahead and turn off this recorder then. It's now 2:42 p.m.

A. Okay.

Transcribed by Edith McBurney on 05-01-12.

04/09/2012 12:42 PM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
						X

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PLUCKER DEBBIE L		F X	SAME

5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
45730 SD HWY 44	Self X Spouse Child Other	SAME

CITY	STATE	8. PATIENT STATUS	CITY	STATE
PARKER	SD	Single Married Other		

ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
57053-9998	( )	Employed Full-Time Student Part-Time Student		( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? X YES NO PLACE (State) SD	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
05 24 2011		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE 05 25 2011		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 2. 8471 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 26 12	11		99242	52	12	100 00	1		ZZ NPI	111N00000X 1366416323
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	X	173892	X YES NO	$ 100 00	$ 00	$ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
04/02/2012
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 571105737
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000080

11/23/2011 08:54 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ ☐ ☐ PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	3. PATIENT'S BIRTH DATE MM DD YY N SEX M ☐ F ☒		4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) 45730 SD HWY 44	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐		7. INSURED'S ADDRESS (No., Street) SAME
CITY PARKER	STATE SD	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY 	STATE
ZIP CODE 57053	TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE 	TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 	10. IS PATIENT'S CONDITION RELATED TO: 		11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER 	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒		a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☒ SD		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME 	c. OTHER ACCIDENT? YES ☐ NO ☒		c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME 	10d. RESERVED FOR LOCAL USE 		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 05 24 2011	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE 05 25 2011		20. OUTSIDE LAB? $ CHARGES YES ☐ NO ☐
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 3. 2. 8471 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 04 11	11		99214		12	130 00	1		NPI	ZZ 111N00000X 1366416323
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

Reviewed slg 11/23/2011 13:50

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☒	26. PATIENT'S ACCOUNT NO. 171942	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $ 130 00	29. AMOUNT PAID $ 00	30. BALANCE DUE $ 130 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Robin Lanpher DC SIGNED 11/08/2011 DATE	32. SERVICE FACILITY LOCATION INFORMATION ROB LANPHER DC 506 N SYCAMORE AVE Sioux Falls SD 571105737 a. 1407834419 b.		33. BILLING PROVIDER INFO & PH # (605 334 8073 Lanpher Chiropractic Office 506 N Sycamore Ave Sioux Falls SD 571105737 a. 1407834419		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000081

11/23/2011 08:54 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L 8470
2. L 7231
3. L 8471
4. L 72885

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 11 02 11		11		98940		1234	52 00	1		NPI	ZZ 111N00000X 1366416323
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☒

26. PATIENT'S ACCOUNT NO.: 171941

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 52 00

29. AMOUNT PAID: 00

30. BALANCE DUE: 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robin Lanpher DC

SIGNED 11/08/2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 571105737
a. 1407834419

33. BILLING PROVIDER INFO & PH # (605 334 8073

Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
b. 1407834419

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000082

11/23/2011 08:54 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) X (ID)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L	3. PATIENT'S BIRTH DATE / SEX: SEX F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44	6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other
7. INSURED'S ADDRESS (No., Street): SAME	
CITY: PARKER / STATE: SD	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY / STATE	
ZIP CODE: 57053 / TELEPHONE (Include Area Code): ( )	
ZIP CODE / TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES X NO
a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M F	b. AUTO ACCIDENT? YES X NO PLACE (State): SD
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
05 24 2011		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE: 05 25 2011		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. L 8470 2. L 7231 3. L 8471 4. L 72885		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 25 11	11		99213	25	1234	85	00 1		NPI	ZZ 111N00000X
											1366416323
2	10 25 11	11		98940		1234	52	00 1		NPI	ZZ 111N00000X
											1366416323
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	X	171844	X YES NO	$ 137 00	00	137 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC DC
SIGNED 11/02/2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 571105737
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000083

10/31/2011 11:08 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE: 57053 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 3. 8471
2. 7231 4. 72885

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 10 21 11		11		98940		1234	52 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3 Reviewed slg 10/31/2011 13:16										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 171789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 52 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
10/25/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000084

10/31/2011 11:08 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE / SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY / SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. L 8470
2. L 7231
3. L 8471
4. L 72885

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	10 17 11		11	98940		1234	52 00	1		NPI	ZZ 111N00000X 1366416323
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER | SSN EIN ☐ ☒

26. PATIENT'S ACCOUNT NO.: 171746

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 52 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
10/25/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000089

10/24/2011 12:17 PM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE: | SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): MM DD YY: 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8470
2. 7231
3. 8471
4. 72885

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 11 11	11		98940		1234	52 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3	Reviewed slg 10/24/2011 13:29									NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER | SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 171651

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 52 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robin Lanpher DC
10/18/2011
SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073

Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000086

10/24/2011 12:17 PM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	3. PATIENT'S BIRTH DATE SEX M ☐ F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) 45730 SD HWY 44	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) SAME
CITY PARKER	STATE SD	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY	STATE
ZIP CODE 57053	TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE	TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) YES ☒ NO ☐ SD	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☒	c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 05 24 2011	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE 05 25 2011		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 3. 8471 2. 7231 4. 72885		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 10 12 11	11		98940		1234	52 00	1		ZZ NPI	111N00000X 1366416323
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
☒	171652	YES ☒ NO ☐	$ 52 00	$ 00	$ 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
Robin Lanpher DC 10/18/2011 SIGNED DATE	ROB LANPHER DC 506 N SYCAMORE AVE Sioux Falls SD 57110 a. 1407834419 b.	(605) 334 8073 Lanpher Chiropractic Office 506 N Sycamore Ave Sioux Falls SD 571105737 a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000087

10/24/2011 12:17 PM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE / SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH / SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH / SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM ___ TO ___

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM ___ TO ___

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 3. 8471
2. 7231 4. 72885

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 10 13 11		11		98940		1234	52 00	1		ZZ NPI	111N000000X 1366416323
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 171653

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 52 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
10/18/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000088

10/14/2011 09:34 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID) X	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	3. PATIENT'S BIRTH DATE SEX F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) 45730 SD HWY 44	6. PATIENT RELATIONSHIP TO INSURED Self X Spouse Child Other	7. INSURED'S ADDRESS (No., Street) SAME
CITY PARKER STATE SD	8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student	CITY STATE
ZIP CODE 57053 TELEPHONE (Include Area Code) ( )		ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES X NO	a. INSURED'S DATE OF BIRTH SEX MM DD YY M F
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F	b. AUTO ACCIDENT? PLACE (State) X YES NO SD	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO	c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
SIGNATURE ON FILE
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT: 05 24 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE 05 25 2011		20. OUTSIDE LAB? $ CHARGES YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 3. 8471 2. 7231 4. 7241		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10 03 11		11		98940		1234	52 00	1		ZZ NPI	111N00000X 1366416323
2											NPI	
3											NPI	
4	Reviewed slg 10/14/2011 15:18										NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN X	26. PATIENT'S ACCOUNT NO. 171523	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 52 00
29. AMOUNT PAID $ 00	30. BALANCE DUE $ 52 00		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
10/11/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
1407834419 a.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
1407834419 a.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08/05)

09/30/2011 10:00 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ☐ ☐ ☐ — PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) PLUCKER DEBBIE L	3. PATIENT'S BIRTH DATE SEX F ☒	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) 45730 SD HWY 44	6. PATIENT RELATIONSHIP TO INSURED Self ☒ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) SAME
CITY: PARKER — STATE: SD	8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY — STATE
ZIP CODE: 57053 — TELEPHONE (Include Area Code): ( )		ZIP CODE — TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒	a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) YES ☒ NO ☐ SD	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☒	c. INSURANCE PLAN NAME OR PROGRAM NAME UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE
SIGNED _____

14. DATE OF CURRENT: 05 24 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ____ 17b. NPI ____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO
19. RESERVED FOR LOCAL USE 05 25 2011		20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 8470 — 3. 8471 2. 7231 — 4. 7241		22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 21 11		11		98940		1234	52 00	1		NPI	ZZ 111N00000X 1366416323
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

Reviewed slg
09/30/2011
12:52

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	☐ ☒	171270	YES ☐ NO ☐	$ 52 00	$ 00	52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
09/27/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08/05)

09/30/2011 10:00 AM

Rob Lanpher, D.C.

506 N. Sycamore Ave.
Sioux Falls, SD 57110

IF PAYING BY CREDIT, FILL OUT BELOW

☐ MasterCard	☐ Visa	☐ Discover	☐ American Express
Card Number		Amount	
Signature		Expiration Date	

Amount Enclosed: _____

Account Number: 7780

Debbie L. Plucker
45730 SD HWY 44
Parker, SD 57053

Statement ID	Statement Date	Statement Message
21487118	09/27/2011	Payment due 10/20/11. Please call 605-334-8073 with questions or to make arrangements.

Reference	Account	Patient	Incident	Last Payment Date	Last Payment Amount
P1	7780	Plucker, Debbie L.	MVA	(None)	(None)

Date	Patient	Ins, Bill Date	Dr	CPT, Code	Description	EOB	Charges	Pending Insurance	Insurance Payments	Patient Payments	Discount & Adjusts.	Patient Balance
05/25/11	P1	06/01/11	D1	99214-25	Office/outpatient visit; est; 25 m...		130.00	0.00				130.00
05/25/11	P1	06/01/11	D1	97035	Ultrasound therapy		25.00	0.00				25.00
05/25/11	P1	06/01/11	D1	98940	Chiropractic manipulation; spina...		52.00	0.00				52.00
05/25/11	P1	06/01/11	D1	72040-22	X-ray exam of neck spine; cervic...		80.00	0.00				80.00
05/25/11	P1	06/01/11	D1	97032	Electrical stimulation		25.00	0.00				25.00
05/31/11	P1	06/06/11	D1	97032	Electrical stimulation		25.00	0.00				25.00
05/31/11	P1	06/06/11	D1	98940	Chiropractic manipulation; spina...		52.00	0.00				52.00
05/31/11	P1	06/06/11	D1	97035	Ultrasound therapy		25.00	0.00				25.00
06/08/11	P1	06/13/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
06/15/11	P1	06/20/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
06/15/11	P1	06/20/11	D1	97035	Ultrasound therapy		25.00	0.00				25.00
06/15/11	P1	06/20/11	D1	97032	Electrical stimulation		25.00	0.00				25.00
06/23/11	P1	06/27/11	D1	98940	Chiropractic manipulation; spina...		52.00	0.00				52.00
06/29/11	P1	07/06/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
07/06/11	P1	07/15/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
07/13/11	P1	07/19/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
07/20/11	P1	07/25/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
08/03/11	P1	08/05/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
08/10/11	P1	08/15/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
08/17/11	P1	08/24/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
08/17/11	P1	08/24/11	D1	99213-25	Office/outpatient visit; est; 15 m...		85.00	0.00				85.00
08/31/11	P1	09/05/11	D1	97032	Electrical stimulation		25.00	0.00				25.00
08/31/11	P1	09/05/11	D1	97035	Ultrasound therapy		25.00	0.00				25.00
08/31/11	P1	09/05/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
09/12/11	P1	09/19/11	D1	98940	Chiropractic manipulation; spina...		52.00	0.00				52.00
09/12/11	P1	09/19/11	D1	97035	Ultrasound therapy		25.00	0.00				25.00
09/12/11	P1	09/19/11	D1	97032	Electrical stimulation		25.00	0.00				25.00
09/14/11	P1	09/19/11	D1	98941	Chiropractic manipulation; spina...		60.00	0.00				60.00
09/21/11	P1	09/23/11	D1	98940	Chiropractic manipulation; spina...		52.00	0.00				52.00

Doctor Legend

D1 Rob R. Lanpher DC DABCO Chiropractor

Patient and Incident		Current	Over 30	Over 60	Over 90	Balance
Debbie L. Plucker (7780)	Patient Portion:	324.00	265.00	180.00	696.00	1,465.00
MVA	Insurance Portion:	0.00	0.00	0.00	0.00	0.00
					Please pay this amount:	1,465.00

09/21/2011 09:22 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ ☐ ☐ — PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare #)	MEDICAID ☐ (Medicaid #)	TRICARE CHAMPUS ☐ (Sponsor's SSN)	CHAMPVA ☐ (Member ID#)	GROUP HEALTH PLAN ☐ (SSN or ID)	FECA BLK LUNG ☐ (SSN)	OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE / SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER — STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY — STATE

ZIP CODE: 57053 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH / SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH / SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM — TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 — 3. 8471
2. 7231 — 4. 7241

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 12 11		11		98940		1234	52 00	1		ZZ	111N00000X
										NPI	1366416323
2 09 12 11		11		97035		1234	25 00	1		ZZ	111N00000X
										NPI	1366416323
3 09 12 11		11		97032		1234	25 00	1		ZZ	111N00000X
										NPI	1366416323
4										NPI	
5										NPI	
6										NPI	

Reviewed sig 09/21/2011 13:23

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN ☐ EIN ☒	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
		171152		$ 102 00	$ 00	102 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to the bill and are made a part thereof.)
Robin Lanpher DC
09/19/2011
SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

DP000092

09/21/2011 09:22 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE: 57053 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8470 3. 8471

2. 7231 4. 7241

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 14 11		11		98941		1234	60 00	1		ZZ	111N00000X
										NPI	1366416323
2										NPI	
3										NPI	
4										NPI	
5 Reviewed slg 09/21/2011 13:23										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 171153

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robin Lanpher DC

09/19/2011

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110

a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605 334 8073

Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737

a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UP000093

09/09/2011 09:20 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ PICA ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE: 57053 TELEPHONE (Include Area Code): ( )

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 3. 8471
2. 7231 4. 7241

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID #
1 08 31 11		11		98941		1234	60 00	1		NPI	ZZ 111N00000X 1366416323
2 08 31 11		11		97035		1234	25 00	1		NPI	ZZ 111N00000X 1366416323
3 08 31 11		11		97032		1234	25 00	1		NPI	ZZ 111N00000X 1366416323
4										NPI	
5										NPI	
6										NPI	

Reviewed slg 09/13/2011 13.21

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 170956

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 110 00

29. AMOUNT PAID: 00

30. BALANCE DUE: 110 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
09/05/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419

33. BILLING PROVIDER INFO & PH # (605 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000094

09/02/2011 09:37 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE: SEX F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State) SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY 05 24 2011 | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8470 | 3. 8471

2. 7231 | 4. 7241

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 17 11	11		99213	25	1234	85	00	1	ZZ NPI	111N00000X 1366416323
2	08 17 11	11		98941		1234	60	00	1	ZZ NPI	111N00000X 1366416323
3										NPI	
4										NPI	
5										NPI	
6										NPI	

Reviewed sig 09/02/2011 10:53

25. FEDERAL TAX I.D. NUMBER	SSN EIN ☒	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
		170779		$ 145 00	$ 00	145 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robin Lanpher DC
SIGNED | 08/24/2011 DATE

32. SERVICE FACILITY LOCATION INFORMATION

ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605 334 8073

Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000095

08/22/2011 09:50 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE: MM DD YY | SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☒ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH: MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): MM DD YY: 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM | TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8470 | 3. 8471

2. 7231 | 4. 7241

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 10 11	11		98941		1234	60 00	1		ZZ NPI	ZZ 111N00000X 1366416323
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

Reviewed sig 08/22/2011 11.12

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
	☐ ☒	170701	YES ☒ NO ☐	$ 60 00	$ 00	60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robin Lanpher DC

SIGNED | DATE: 08/15/2011

32. SERVICE FACILITY LOCATION INFORMATION

ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110

a. 1407834419 b.

33. BILLING PROVIDER INFO & PH #: (605 334 8073

Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737

a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000096

08/17/2011 09:10 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE | SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: 05 24 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 3. 8471
2. 7231 4. 7241

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	08 03 11	11		98941		1234	60 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3	Reviewed slg 08/17/2011 11:28									NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER | SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: 170632

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
08/05/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08/05)

OF000097

08/03/2011 08:30 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER STATE: SD

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 57053 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY: 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 8470 3. 8471

2. 7231 4. 7241

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 07 20 11		11		98941		1234	60 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3 Reviewed slg 08/03/2011 09:22										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN [X]

26. PATIENT'S ACCOUNT NO.: 170457

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Robin Lanpher DC 07/25/2011

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073

Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

DP000098

07/25/2011 09:19 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ☐ ☐ ☐ | PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): ☐ YES ☒ NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? ☒ YES ☐ NO | PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☒ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☒ NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: 05 24 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? ☐ YES ☐ NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 3. 8471
2. 7231 4. 7241

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	07 06 11		11		98941		1234	60 00	1		NPI ZZ 111N00000X 1366416323
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

Reviewed slg 07/25/2011 12.22

25. FEDERAL TAX I.D. NUMBER: SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 170298

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
07/15/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

07300099

07/25/2011 09:19 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE / SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ | Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State) SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: 05 24 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 2. 7231 3. 8471 4. 7241

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07 13 11		11	98941		1234	60 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3	Reviewed slg 07/25/2011 12:22									NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER | SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 170377

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC 07/29/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

GP000100

07/14/2011 09:26 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA ☐ ☐ ☐ — PICA ☐ ☐ ☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER — STATE: SD

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY — STATE

ZIP CODE: 57053 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ NO ☐ PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED: SIGNATURE ON FILE — DATE

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SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): MM DD YY 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. L 8470 — 3. L 8471
2. L 7231 — 4. L 7241

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 06 29 11		11		98941		1234	60 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3										NPI	
4										NPI	
5 Reviewed slg 07/14/2011 09:58.										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER — SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 170242

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 60 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 60 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
07/06/2011
SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

OF000101

07/01/2011 09:14 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		
						X			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE	SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
PLUCKER DEBBIE L				F X			SAME		
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)		
45730 SD HWY 44			Self X	Spouse	Child	Other	SAME		
CITY		STATE	8. PATIENT STATUS				CITY		STATE
PARKER		SD	Single	Married	Other				
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE	TELEPHONE (Include Area Code)	
57053	( )		Employed	Full-Time Student	Part-Time Student			( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER		
							4001032727		
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH MM DD YY	SEX	
			YES	X NO				M	F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY	SEX		b. AUTO ACCIDENT?	PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME		
	M	F	X YES	NO	SD				
c. EMPLOYER'S NAME OR SCHOOL NAME			c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME		
			YES	X NO			UNITED FIRE AND CASUALTY		
d. INSURANCE PLAN NAME OR PROGRAM NAME			10d. RESERVED FOR LOCAL USE				d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
							YES X NO	If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
05 24 2011		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
	17b. NPI	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
05 25 2011		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. L 8470 3. L 8471		
2. L 7231 4. L 7241		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	06 15 11	11		98941		1234	60 00	1		ZZ NPI	111N00000X 1366416323
2	06 15 11	11		97035		1234	25 00	1		ZZ NPI	111N00000X 1366416323
3	06 15 11	11		97032		1234	25 00	1		ZZ NPI	111N00000X 1366416323
4				Reviewed slg 07/01/2011 10:21						NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
		X	170052	X YES NO	$ 110 00	$ 00	110 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
06/20/2011
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH # (605 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM 1500 (08/05)

SF000102

07/01/2011 09:14 AM

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

CARRIER

PICA ☐ | PICA ☐

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | TRICARE CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (Member ID#) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☒ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE | SEX: F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ | Spouse ☐ | Child ☐ | Other ☐

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER | STATE: SD

8. PATIENT STATUS: Single ☐ | Married ☐ | Other ☐ | Employed ☐ | Full-Time Student ☐ | Part-Time Student ☐

CITY | STATE

ZIP CODE: 57053 | TELEPHONE (Include Area Code): ( )

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES ☐ | NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☒ | NO ☐ | PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ | NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ | NO ☒ If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE | DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: 05 24 2011 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES ☐ NO ☐ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 3. 8471
2. 7231 4. 7241

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06 23 11	11		98940		1234	52 00	1		ZZ NPI	111N00000X 1366416323
2										NPI	
3	Reviewed slg 07/01/2011 10:21									NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER | SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: 170162

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☒ NO ☐

28. TOTAL CHARGE: $ 52 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: $ 52 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
06/27/2011
SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a 1407834419 b

33. BILLING PROVIDER INFO & PH # (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a 1407834419 b

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

DF000103

06/17/2011 09:39 AM

Reviewed slg 06/17/2011 10:16

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	OTHER X (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	PLUCKER DEBBIE L
3. PATIENT'S BIRTH DATE / SEX	F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	SAME
5. PATIENT'S ADDRESS (No., Street)	45730 SD HWY 44
6. PATIENT RELATIONSHIP TO INSURED	Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	SAME
CITY	PARKER
STATE	SD
8. PATIENT STATUS	Single / Married / Other; Employed / Full-Time Student / Part-Time Student
CITY	
STATE	
ZIP CODE	57053
TELEPHONE (Include Area Code)	( )
ZIP CODE	
TELEPHONE (Include Area Code)	( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / NO X
a. INSURED'S DATE OF BIRTH / SEX	M / F
b. OTHER INSURED'S DATE OF BIRTH / SEX	M / F
b. AUTO ACCIDENT? / PLACE (State)	YES / NO X / SD
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES / NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME	UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / NO X — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	05 24 2011
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	FROM TO
19. RESERVED FOR LOCAL USE	05 25 2011
20. OUTSIDE LAB?	YES / NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. L 8470 — 3. L 8471 — 2. L 7231 — 4. L 7241
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 08 11	11		98941		1234	60 00	1		ZZ NPI	111N00000X 1366416323
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X / NO	28. TOTAL CHARGE $ 60 00	29. AMOUNT PAID $ 00	30. BALANCE DUE 60 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Robin Lanpher DC SIGNED 06/13/2011 DATE	32. SERVICE FACILITY LOCATION INFORMATION ROB LANPHER DC 506 N SYCAMORE AVE Sioux Falls SD 57110 a. 1407834419 b.		33. BILLING PROVIDER INFO & PH # (605) 334 8073 Lanpher Chiropractic Office 506 N Sycamore Ave Sioux Falls SD 571105737 a. 1407834419 b.		

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UP000104

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

06/10/2011 09:15 AM

Reviewed slg 06/10/2011 09:59
UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) / MEDICAID (Medicaid #) / TRICARE CHAMPUS (Sponsor's SSN) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (SSN or ID) / FECA BLK LUNG (SSN) / OTHER (ID)	X (ID)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	PLUCKER DEBBIE L
3. PATIENT'S BIRTH DATE / SEX	F X
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	SAME
5. PATIENT'S ADDRESS (No., Street)	45730 SD HWY 44
6. PATIENT RELATIONSHIP TO INSURED	Self X / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street)	SAME
CITY	PARKER
STATE	SD
8. PATIENT STATUS	Single / Married / Other; Employed / Full-Time Student / Part-Time Student
CITY / STATE	
ZIP CODE	57053
TELEPHONE (Include Area Code)	( )
ZIP CODE / TELEPHONE (Include Area Code)	( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	
10. IS PATIENT'S CONDITION RELATED TO:	
11. INSURED'S POLICY GROUP OR FECA NUMBER	4001032727
a. OTHER INSURED'S POLICY OR GROUP NUMBER	
a. EMPLOYMENT? (Current or Previous)	YES / X NO
a. INSURED'S DATE OF BIRTH / SEX	MM DD YY / M / F
b. OTHER INSURED'S DATE OF BIRTH / SEX	MM DD YY / M / F
b. AUTO ACCIDENT? / PLACE (State)	YES / X NO / SD
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. EMPLOYER'S NAME OR SCHOOL NAME	
c. OTHER ACCIDENT?	YES / X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	UNITED FIRE AND CASUALTY
d. INSURANCE PLAN NAME OR PROGRAM NAME	
10d. RESERVED FOR LOCAL USE	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	YES / X NO — If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	05 24 2011
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	
17a. / 17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE	05 25 2011
20. OUTSIDE LAB? / $ CHARGES	YES / NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)	1. 8470 2. 7231 3. 8471 4. 7241
22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.	
23. PRIOR AUTHORIZATION NUMBER	

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	05 31 11	11	11		98940		1234	52 00	1		ZZ / NPI	111N00000X / 1366416323
2	05 31 11	11	11		97035		1234	25 00	1		ZZ / NPI	111N00000X / 1366416323
3	05 31 11	11	11		97032		1234	25 00	1		ZZ / NPI	111N00000X / 1366416323
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER / SSN EIN	X
26. PATIENT'S ACCOUNT NO.	169856
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	X YES / NO
28. TOTAL CHARGE	$ 102 00
29. AMOUNT PAID	00
30. BALANCE DUE	102 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	Robin Lanpher DC 06/06/2011 SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION	ROB LANPHER DC 506 N SYCAMORE AVE Sioux Falls SD 57110 a. 1407834419 b.
33. BILLING PROVIDER INFO & PH #	(605 334 8073 Lanpher Chiropractic Office 506 N Sycamore Ave Sioux Falls SD 571105737 a. 1407834419

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UP000106

06/06/2011 11:24 AM

Reviewed slg 06/06/2011 14:38

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

UNITED FIRE CASUALTY
PO BOX 73909
CEDAR RAPIDS IA 524073909

Waiting for med auth & then recs - slg

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) — X

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): PLUCKER DEBBIE L

3. PATIENT'S BIRTH DATE / SEX: F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 45730 SD HWY 44

6. PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: PARKER — STATE: SD

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY — STATE

ZIP CODE: 57053 — TELEPHONE (Include Area Code): ( )

ZIP CODE — TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 4001032727

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES NO X

a. INSURED'S DATE OF BIRTH / SEX: M F

b. OTHER INSURED'S DATE OF BIRTH / SEX: M F

b. AUTO ACCIDENT? YES X NO — PLACE (State): SD

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: UNITED FIRE AND CASUALTY

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO X — If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 24 2011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: FROM — TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: FROM — TO

19. RESERVED FOR LOCAL USE: 05 25 2011

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 8470 — 3. 8471
2. 7231 — 4. 7241

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 25 11		11		99214	25	1234	130	00 1		ZZ	111N00000X
										NPI	1366416323
2 05 25 11		11		98940		1234	52	00 1		ZZ	111N00000X
										NPI	1366416323
3 05 25 11		11		97035		1234	25	00 1		ZZ	111N00000X
										NPI	1366416323
4 05 25 11		11		97032		1234	25	00 1		ZZ	111N00000X
										NPI	1366416323
5 05 25 11		11		72040	22	1234	80	00 1		ZZ	111N00000X
										NPI	1366416323
6										ZZ	
										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN EIN X

26. PATIENT'S ACCOUNT NO.: 169769

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 312 00

29. AMOUNT PAID: $ 00

30. BALANCE DUE: 312 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Robin Lanpher DC
SIGNED — DATE: 06/01/2011

32. SERVICE FACILITY LOCATION INFORMATION
ROB LANPHER DC
506 N SYCAMORE AVE
Sioux Falls SD 57110
a. 1407834419 b.

33. BILLING PROVIDER INFO & PH #: (605) 334 8073
Lanpher Chiropractic Office
506 N Sycamore Ave
Sioux Falls SD 571105737
a. 1407834419 b.

PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

UF000106

UNITED FIRE GROUP®

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company
United Fire Lloyds

MAY 25 2011

DEBBIE PLUCKER
45730 SD HIGHWAY 44
PARKER, SD 57053-5624

RE: Claim Number: 4001032727
Policy Number: 90625038
Ins. Driver: DEBBIE PLUCKER
Date of Loss: 05-24-2011
Claimant: DEBBIE PLUCKER
Loss Location: I-29 N AT (MRM 071-63 + .108 HARRISBURG SD

Dear Insured:

We have received notice of your loss of 05-24-2011.

The adjuster assigned to service your claim is:

SHERRI WADE
PO BOX 73909
CEDAR RAPIDS, IA 52407-3909

Phone No: 319-399-5758
Branch Fax: 800-863-1703

If you wish to visit with your adjuster and have not yet heard from the person assigned to your claim please feel free to contact him/her at the above number.

If you are unable to contact the adjuster and need immediate assistance, please call the office as shown on this letterhead.

Sincerely,

UNITED FIRE & CASUALTY COMPANY
Claims Department

May 26, 2011

Debbie Plucker
45730 SD Highway 44
Parker, SD 57053

RE: Claim: 4001032727
Loss Date: 5/24/11

Dear Ms. Plucker,

We have reviewed your claim and your policy provides Medical Payments Coverage, which will apply to this accident. Medical Payments Coverage pays for reasonable and necessary medical treatment that is reported to us and incurred within 3 years of this accident. This coverage is subject to the $5,000.00 limit specified in your policy.

Please know that with this coverage will seek recovery for any expenses we pay from Liberty Mutual. You will need to protect our rights when you are ready to settle.

In order to handle your medical claim, we will need the Medical Authorization and Treatment Provider List forms completed and returned to us. The Medical Authorization will allow us to obtain the bills and records associated with this loss. The Treatment Provider List simply tells us who you are treating with.

Because you are a Medicare recipient, we have also enclosed their Consent to Release Form. This form will allow Medicare to communicate with us so we can monitor your billings.

Lastly, it appears that Liberty Mutual is taking care of the damages to your vehicle. If you find out they are not, you have Collision Coverage available to you subject to a $500.00 deductible. Please let us know if you need to use this coverage.

Please let us know what questions you have. We can be reached at 800-343-9131 ext 5758.

Thank you.
Sincerely,

Sherri Wade, Claims Representative

UNITED FIRE GROUP

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company

United Fire Lloyds
American Indemnity Company
Texas General Indemnity Company

Medical Provider List

Claim#: 4001032727

Insured/Claimant: Debbie Plucker

List the name and address of each hospital, clinic, doctor or chiropractor where you received medical treatment:

Medical Providers:

Name _____

Address _____

City, State, Zip Code _____

Phone _____

Name _____

Address _____

City, State, Zip Code _____

Phone _____

Name _____

Address _____

City, State, Zip Code _____

Phone _____

If more space is required, use a separate page.

CLAIM NO.: 4001032727

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: _____
(Physician, Hospital, or other)

I authorize the above named party to release to United Fire and Casualty Company information from the medical record of the below named patient. This request is being made at the request of the individual who signed below.

Patient's Name: Plucker, Debbie
Patient's Address: 45730 SD Highway 44, Parker, SD 57053
Patient's Birth Date: Social Security No.

THIS CONSENT TO RELEASE INFORMATION IS LIMITED TO THE FOLLOWING:

☒ Any and all medical records, including reports involving alcohol, drug abuse, or psychiatric treatment or recovery (if applicable) from 5/24/11 to Present.

☐ Or selected medical records, including reports involving alcohol, drug abuse, or psychiatric treatment or recovery (if applicable) from to .

Use the checklist below to specify category(s) necessary for copying:

☒ History & Physical Exam
☒ Discharge Summary
☒ Operative Reports
☒ Pathology Reports
☒ Consultation Reports
☒ X-ray Reports
☒ Laboratory Reports
☒ Outpatient Information
☒ Progress Notes
  ☒ Physician's
  ☒ Nurse's
☐ Other (Please specify)

This authorization is valid for 12 months from the date of signing. It may be revoked in writing at any time. A photocopy of this authorization will be treated in the same manner as the original.

I acknowledge that information to be released may include material that is protected by state and/or federal law applicable to mental health, alcohol/drug abuse, HIV/AIDS or all of these. My signature authorizes release of all such information as specified above.

I acknowledge that information used or disclosed pursuant to this authorization may be subject to re-disclosure by United Fire and Casualty Company without further authorization.

Where information has been disclosed from records protected by federal law for alcohol/drug abuse records, by state law for mental health records or HIV/AIDS related records, federal requirements (42 CFR Part 2) and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse, mental health or HIV/AIDS information.

_____ _____
Signature of Patient/Guardian Relationship to Patient if Signed by Guardian

_____ _____
Date of Signature Reason Patient Unable to Sign

CD4030 (04/032003)

UF000110

July 13, 2011

Debbie Plucker
45730 SD Highway 44
Parker, SD 57053

RE: Claim: 4001032727
Loss Date: 5/24/11

Dear Ms. Plucker,

This letter serves as a friendly reminder that in order to assist you with this claim, you must fulfill the obligations outlined in your policy. Your Personal Auto Policy states:

AGREEMENT

In return for payment of the premium and subject to all the terms of this policy, we agree with you as follows:

PART E – DUTIES AFTER AN ACCIDENT OR LOSS

We have no duty to provide coverage under this policy unless there has been full compliance with the following duties:

B. A person seeking any coverage must:

1. Cooperate with us in the investigation, settlement or defense of any claim or suit.
2. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
3. Submit, as often as we reasonably require:

a. To physical exams by physicians we select. We will pay for these exams.
b. To examination under oath and subscribe the same.

4. Authorize us to obtain:

a. Medical reports; and
b. Other pertinent records.

5. Submit a proof of loss when required by us.

Currently we have not received the Medical Authorizations we requested and therefore are not able to process your medical claim. We have enclosed these forms again for your completion. Additionally you will find the forms we received from Medicare that are also necessary in order to assist you.

Please let us know what questions you have. We can be reached Monday through Friday from 8:00am until 4:30pm at 800-343-9131 ext 5758.

Thank you.
Sincerely,

Sherri Wade, Claims Representative

07/22/2011 09:18 AM

UNITED FIRE GROUP

United Fire & Casualty Company
United Life Insurance Company
Addison Insurance Company
Lafayette Insurance Company
United Fire & Indemnity Company

United Fire Lloyds
American Indemnity Company
Texas General Indemnity Company

Medical Provider List

Claim#: 4001032727

Insured/Claimant: Debbie Plucker

List the name and address of each hospital, clinic, doctor or chiropractor where you received medical treatment:

Medical Providers:

Name Dr. Robin Lanpher
Address 506 N. Sycamore Avenue
City, State, Zip Code Sioux Falls SD 57110
Phone 605-334-8073

Name _____
Address _____
City, State, Zip Code _____
Phone _____

Name _____
Address _____
City, State, Zip Code _____
Phone _____

If more space is required, use a separate page.

07/22/2011 09:18 AM Only Original is Valid. No copies Are Valid.
Must Be Signed In 'Red Ink' to be Valid.

CLAIM NO.: 4001032727

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To: Dr. Robin R. Lanpher
Lanpher Chiropractic
(Physician, Hospital, or other)

Reviewed slg 07/22/2011 12:44

I authorize the above named party to release to United Fire and Casualty Company information from the medical record of the below named patient. This request is being made at the request of the individual who signed below.

Patient's Name: Plucker, Debbie
Patient's Address: 45730 SD Highway 44, Parker, SD 57053
Patient's Birth Date: Social Security No.

THIS CONSENT TO RELEASE INFORMATION IS LIMITED TO THE FOLLOWING:

☒ Any and all medical records, [redacted] from 5/24/11 to Present.

☐ Or selected medical records, including reports involving alcohol, drug abuse, or psychiatric treatment or recovery (if applicable) from to

Use the checklist below to specify category(s) necessary for copying:

☒ History & Physical Exam	☒ Consultation Reports	☒ Progress Notes
☒ Discharge Summary	☒ X-ray Reports	☒ Physician's
☒ Operative Reports	☒ Laboratory Reports	☒ Nurse's
☒ Pathology Reports	☒ Outpatient Information	☐ Other (Please specify)

This authorization is valid for 3 (three) months from the date of signing. It may be revoked in writing at any time.

[redacted]

Signature of Patient/Guardian

Relationship to Patient if Signed by Guardian

06-01-2011
Date of Signature

Reason Patient Unable to Sign

06-01-2011

CD4030 (04/032003)

UF000114